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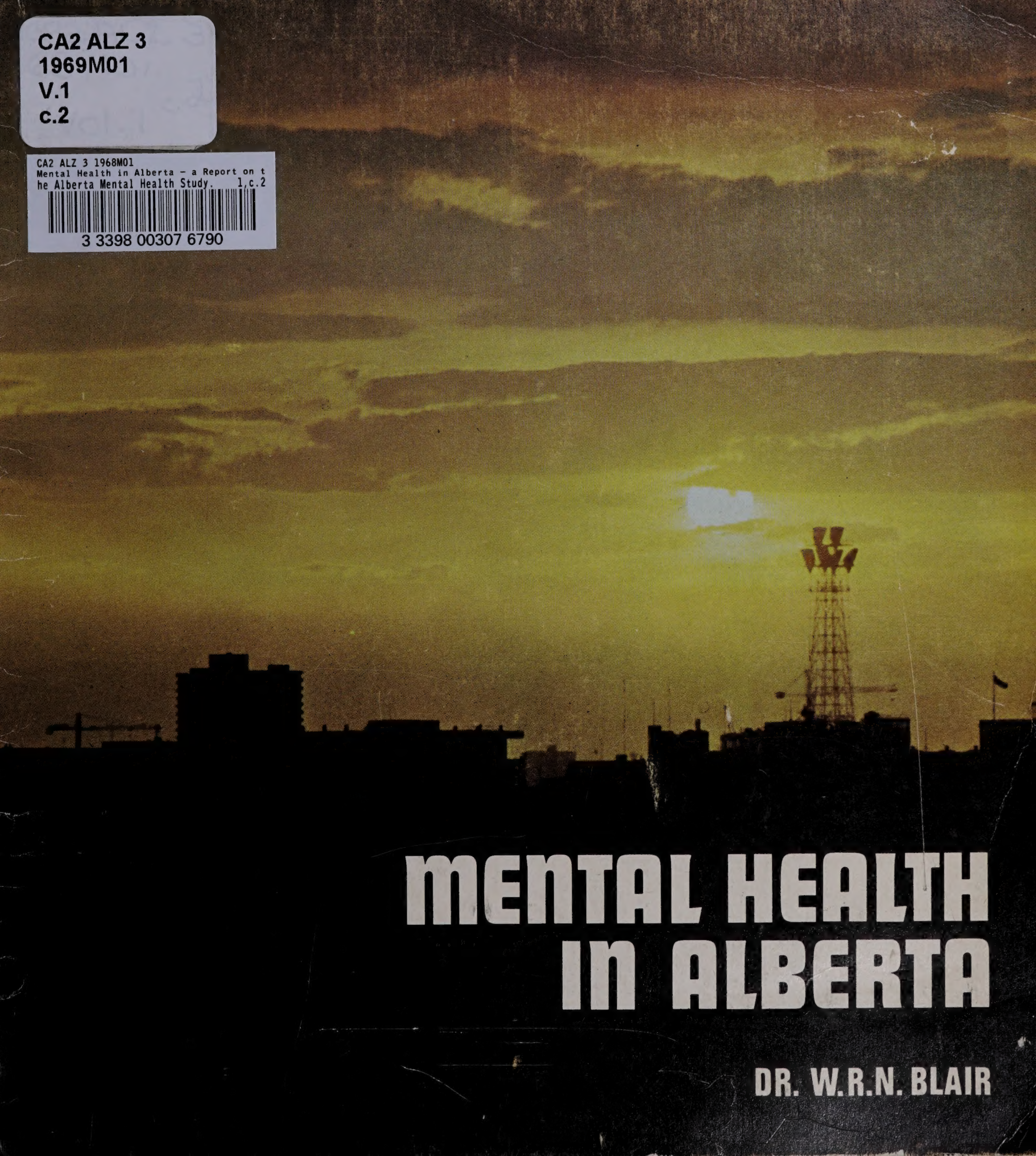

MENTAL HEALTH IN ALBERTA

DR. W.R.N. BLAIR

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MENTAL HEALTH IN ALBERTA

A Report on the

ALBERTA MENTAL HEALTH STUDY, 1968

DR. W. R. N. BLAIR

Head, Department of Psychology
University of Calgary

HUMAN RESOURCES RESEARCH AND DEVELOPMENT

EXECUTIVE COUNCIL — GOVERNMENT OF ALBERTA

Edmonton, Alberta

April, 1969

PREFACE

This report is the result of a year's study and discussion by many hundreds of people throughout the Province of Alberta, including members of associations, private individuals and members of the Mental Health Division itself. The Alberta Mental Health Study was viewed by its sponsors, the Government, and by participants as a critical examination of all aspects of mental health services within the Province. The objective of the Study was to produce ideas and recommendations which would help improve upon those services to the point where they would become comprehensive, integrated and adequate.

The purpose of the Study was not to fix blame for past mistakes or current inadequacies. If it is used in that context it will not achieve the aims of its contributors. Instead, it is our hope that the report on the Study will be used by the Government of Alberta and interested associations, institutions and individuals within the Province as a guide and starting point for necessary change and development in Alberta's mental health services. Another full-scale study of those services should take place in not more than three years' time and there should be a continuous, routine evaluation of the effectiveness of programs and the adequacy of services in the meantime.

Members of the Division of Mental Health at headquarters and at other locations participated effectively in critical self-examination during the Study and many of the proposals made in this report originated with them. All possible cooperation was extended to study group chairmen, research personnel, outside consultants and myself by the Government, and particularly by the Director, the Superintendents and other members of the Division of Mental Health. The Director of the Division has held his appointment for only two years so deficiencies in the mental health services system, which have taken years to accumulate, clearly cannot be attributed to him. There is an awareness of many deficiencies within the system and some corrective action has been taken since this Study began. Readers of this document should appreciate that the current system is the target for criticism and change, not the many dedicated people who have been trying to make it work.

This report is concerned with a total mental health system. Special attention will be assigned to organization from government level to that of the community. In addition, the diagnostic, treatment, rehabilitative and preventive capabilities of the system, the evaluation of the effectiveness of current programs and the strength of supportive research will be singled out for special attention. The importance of the family physician, active treatment general hospitals, clinics, health units, resources in the school system and in the community at large will be stressed. Finally, the report will focus on the provision, development and sensitive management of the people who are vital to the success of any mental health service.

It will assign the highest priority to: organization and administration of health services; an integrated, community-based system for the delivery of care; and personnel for the system and their remuneration, education and development. The importance of improved programs of treatment, rehabilitation and prevention will be stressed and the need for a great deal more research will be documented. In particular, priority will be given to the establishment of psychiatric units in all appropriate active treatment general hospitals. The report will also be concerned with physical facilities, but it will display absolutely no enthusiasm for the building of more long term or "longer term" mental hospitals, under any name, now or in the foreseeable future.

The Study will reveal a need, however, for the allocation of more facilities for emotionally disturbed children and adolescents and for intellectually and neurologically handicapped persons. It will urge the extension of the excellent networks of auxiliary hospitals and nursing homes as essential elements of a new delivery system. It will also stress that there is an important and continuing requirement for the present provincial mental hospitals and clinics, but with revised roles and orientation.

I wish to express my sincere appreciation to the people who did most of the work on the Study. They served with willingness, personal sacrifice and great effect. I know they will consider themselves amply rewarded if improvements in the vital areas outlined above are made.

I also wish to commend the staff of the mental hospitals, who have served constantly and devotedly in a defective system, which is not of their making, while providing the best care within their means for the persons committed to their responsibility.

The recommendations made in the report have the unanimous endorsation of the Study Group Chairmen and the regular participants in the public hearings. Their names are recorded below.

W.R.n. Blair

W.R.N. Blair, Ph.D.
Director
Alberta Mental Health Study

Calgary, February 1969

Dr. J. Chambers, Edmonton
Mrs. Terry Davis, R.N., Edmonton
Dr. P.O. Davidson, Calgary
Dr. J. Guild, Edmonton
Prof. A.J.B. Hough, Edmonton
Dr. D.K. Miyauchi, Calgary
Dr. J.G. Paterson, Edmonton
Dr. K.I. Pearce, Calgary
Dr. D.O.C. Rapier, Edmonton
Dean J.M.A. Robinson, Calgary
Dr. T.C. Saunders, Calgary
Dr. F.H. Tyler, Calgary
Dr. H.M. Wojcicki, Edmonton
Dr. K.A. Yonge, Edmonton

MENTAL HEALTH IN ALBERTA

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INTRODUCTION

Background

The Alberta Mental Health Study was announced by the Premier and the Minister of Health in November 1967 at a press conference in Edmonton. (See Appendix 1.)

The announcement followed the publication of A White Paper on Human Resources Development (1) by the Honourable E.C. Manning, Premier of Alberta, in March 1967. The White Paper recorded, on page 57, a concern about present programs and facilities for the "treatment and rehabilitation of the mentally ill". It also indicated that the Government would initiate within the next year a study designed "to achieve a standard of excellence" in the field of mental health.

> (The White Paper recorded similar concern and planned action with respect to the custody and rehabilitation of criminals. The two studies, one on penology and the other on mental health, were undertaken concurrently with liaison provided through what was called the Penology Consultative Group. The Penology Study, directed by Mr. W.T. McGrath, Executive Secretary of the Canadian Corrections Association, has concluded and the Report on the Alberta Penology Study (2) was published November 10, 1968.)

The White Paper was notable in another context of interest here. It announced, on page 56, the commitment of the Government "as a matter of policy" to increase research effort in the field of human resources development. Because Alberta's research efforts in mental health have been relatively insignificant, that commitment was considered particularly encouraging by the participants in the Alberta Mental Health Study.

Organization of the Study

1. Study Groups

Eleven study groups were formed to examine and report upon broad areas of concern in the field of mental health. Their chairmen and the topics studied were as listed below. The full membership is shown at Appendix 2.

Organization and Administration of Mental Health - Dean J.M.A. Robinson, Faculty of Business, University of Calgary.

Manpower for Mental Health Education and Training - Dr. Keith A. Yonge, Head, Department of Psychiatry, University of Alberta, Edmonton.

Research in Mental Health - Dr. P.O. Davidson, Department of Psychology, University of Calgary.

Emotionally Disturbed Children and Adolescents - Dr. D.O.C. Rapier, Department of Psychiatry, University of Alberta, Edmonton.

Intellectually and Neurologically Handicapped Children, Dr. Juanita Chambers, Department of Educational Psychology, University of Alberta, Edmonton.

Mental Health Problems of University Students - Dr. C.M. Christensen, then Director of Student Counselling Services, University of Calgary (now with the Ontario Institute for Studies in Education).

Northern Mental Health Problems - Dr. D.K. Miyauchi, Department of Psychiatry, Foothills Hospital, Calgary.

Community Facilities for Mental Health - Dr. F.H. Tyler, Director, School of Social Welfare, University of Calgary.

Addiction - Dr. H.M. Wojcicki, Specialist in Psychiatry, Edmonton.

Relative Roles of Professional Personnel - Dr. K.I. Pearce, Director of Psychiatry, Foothills Hospital, Calgary.

Pupil Personnel Services in Alberta Schools - Dr. J.G. Paterson, now Director of Counselling Services, Faculty of Education, University of Alberta, Edmonton.

2. Special Projects

In addition to the broad-ranging and longer-term tasks of the eleven study groups, specific research projects were commissioned and undertaken by individuals or small groups as indicated:

Incidence of Mental Illness in Alberta - Dr. J.E. Boyd, Department of Psychology, University of Calgary.

Mental Health in Industry - Dr. J.E. Boyd.

Alcoholism Problems in Alberta - Dr. J.E. Boyd.

Diagnosis of Mental Illness - Heather Wood, M.A., Guidance Department, Calgary Public School Board.

A Survey of the Treatment of Mental Illness - Heather Wood.

Patient Care in Mental Hospitals and Psychiatric Units - Dr. K.I. Pearce, Foothills Hospital, Calgary.

Mental Health Services in Alberta and Other Areas, a Comparative Study - Reg. P. Farley, University of Calgary.

Mental Health and the Elderly - Prof. A.E.D. Schonfield, University of Calgary.

3. Consultants

Eight outside consultants, named below, from the fields of psychiatry, social work, psychology and mental health research participated in the

Study. Three of them (Berry, Chalke and Jones) visited representative institutions within the Province, met for discussions with the Study Group Chairmen on several occasions and attended the final meeting of the Study Group Chairmen and a public seminar in Calgary in late October.

Dr. F.C.R. Chalke, Vice-Dean, Faculty of Medicine, University of Ottawa.
Dr. R.O. Jones, Head, Department of Psychiatry, Dalhousie University.
Mr. R.G. Berry, Consultant in Psychology, Department of Health, Government of Ontario, Toronto.
Dr. R.W. McDonald, Professor of Social Work, University of Washington, Seattle.
Dr. R.E. Turner, Clarke Institute of Psychiatry, Toronto.
Dr. John Dewan, Ontario Mental Health Foundation, Toronto.
Dr. Colin Smith, Director, Division of Mental Health, Province of Saskatchewan.
Dr. C. Roger Myers, Chairman, Department of Psychology, University of Toronto.

4. Visits

The Director of the Alberta Mental Health Study or his representatives made a number of visits to other provinces, states and countries to discuss mental health programs, organization, research and other related topics. Places visited included: Saskatchewan, Ontario, England, the Netherlands, the Community Health Centre at Fort Logan, Colorado, the National Institute for Mental Health, Washington, D.C., the Bureau of Research in Neurology and Psychiatry at Princeton, New Jersey, projects of the Bureau of Child Research, University of Kansas.

5. Briefs

All interested individuals and associations were invited through public announcements to submit briefs to the Director on any aspect of the Study. Confidential communications were also invited. The Minister of Health conveyed these invitations to members of the Mental Health Division.

Approximately two hundred open briefs, confidential briefs and letters were received. A listing of open briefs is recorded in Volume 2.

6. Public Hearings

Public hearings were held at five locations in the Province: Grande Prairie, Edmonton, Red Deer, Calgary and Lethbridge. Members of the commissions which heard the briefs were:

Dr. W.R.N. Blair, Chairman
Mrs. Joan Campbell, R.N., B.Sc.
Dr. P.O. Davidson
Mrs. Terry Davis, R.N. B.N.
Dr. John Fair
Dr. Julius Guild
Dr. D.K. Miyauchi
Dr. T.C. Saunders
Mr. A.G. Scott, M.A.
Dr. F.H. Tyler

7. Public Seminar

A public seminar was held in the Southern Alberta Jubilee Auditorium, Calgary, on October 25th. At that seminar, the issues, general findings and recommendations of the study groups were presented by their chairmen, as a means of keeping the public informed concerning the progress of the Study.

8. Publication

Summaries or complete reports, which were submitted by the eleven study groups, and by the special project officers will be presented in this volume of Mental Health in Alberta. Volume 2 will contain the open briefs or summaries of those briefs.

9. Orders-in-Council

The Orders-in-Council, which were published in connection with the Alberta Mental Health Study, are at Appendixes 3 to 5.

REFERENCES

1. Manning, Honourable E.C.: A White Paper on Human Resources Development, Edmonton, Alberta, 1967.

2. McGrath, W.T.: Report of the Alberta Penology Study, Edmonton, 1968.

Dr. Jean Pettifor
2731 Crawford Road N.W.
CALGARY

Mr. D.D. Taylor
Principal
St. Francis High School
877 Northmount Drive N.W.
CALGARY

Rev. Robert A. Wallace
Parkdale United Church
2919 9th Avenue N.W.
CALGARY

Emotionally Disturbed Children and Adolescents

Chairman: Dr. D.O.C. Rapier
Department of Psychiatry
University of Alberta
EDMONTON

Members: Dr. H. Barker
422 Medical Arts Building
11010 Jasper Avenue
EDMONTON

Dr. W. Bobey
Division of Mental Health
Guidance Clinic
EDMONTON

Dr. I. De Coutere
Marchand Mansion
116 Street & 100 Avenue
EDMONTON

Rev. Father W. Irwin
Catholic Charities
#4, 9912 109 Street
EDMONTON

Mr. S. Millman
Division of Social Welfare
CALGARY

Intellectually and Neurologically Handicapped Children

Chairman: Dr. Juanita Chambers
Department of Educational Psychology
University of Alberta
EDMONTON

Members:

Dr. E.W. Gauk
Neurologist and Pediatrician
EDMONTON

Dr. S.A. Perkins
Director of Counselling
University of Lethbridge
LETHBRIDGE

Dr. J. Quinn
Director of Psychological Services
Calgary Separate School Board
CALGARY

Mr. Aubrey Teal
Executive Director
Alberta Association of Retarded Children
EDMONTON

Professor Lillian Whyte
Special Education
University of Alberta
EDMONTON

Manpower for Mental Health, Education and Training

Chairman:

Dr. Keith A. Yonge
Department of Psychiatry
University of Alberta
EDMONTON

Members:

Dr. G.M. Ball
Medical Officer of Health
City of Edmonton
EDMONTON

Dr. E.R. Haynes
Assistant Professor in Community Medicine
University of Alberta
EDMONTON

Professor A.J.B. Hough, Director
Student Counselling Services
University of Alberta
EDMONTON

Mr. George McLellan, President
Alberta Division
Canadian Mental Health Association
Consultant Social Worker
EDMONTON

Appendix 2

Miss S. Ryan, Clinical Coordinator
Nursing Education
University of Alberta Hospital
EDMONTON

Dr. H.W. Zingle
Director of Counsellor Education Program
University of Alberta
EDMONTON

Mental Health Problems of University Students

Chairman:
Dr. C.M. Christensen
Director of Counselling Services
University of Calgary
CALGARY

Members:
Professor A.J.B. Hough
Director of Counselling
University of Alberta
EDMONTON

Dr. Stanley A. Perkins
Director of Counselling
University of Lethbridge
LETHBRIDGE

Northern Mental Health Problems

Chairman:
Dr. D.K. Miyauchi
Department of Psychiatry
Foothills Hospital
CALGARY

Members:
Dr. P.O. Davidson
Department of Psychology
University of Calgary
CALGARY

Dr. Charles Hellon
Department of Psychiatry
University of Alberta
EDMONTON

Mr. A.G. Scott
Department of Educational Psychology
University of Alberta
EDMONTON

Organization and Administration of Mental Health Services

Chairman:

Dean J.M.A. Robinson
Faculty of Business
The University of Calgary
CALGARY

Members:

Mrs. Clarence T. Armstrong
Chairman, Visitors Committee
2113 29th Avenue S.W.
CALGARY

Dr. John Dawson, Associate Dean
Faculty of Medicine
The University of Calgary
CALGARY

Dr. I. Gogan, Executive Director
Holy Cross Hospital
2nd Street and 22nd Avenue S.W.
CALGARY

Dr. Julius Guild
Department of Psychiatry
Royal Alexandra Hospital
EDMONTON

Dr. Carl A. Meilicke
Associate Professor and Director
Division of Health Services Administration
Department of Sociology
The University of Alberta
EDMONTON

Pupil Personnel Services in Alberta Schools

Chairman:

Dr. J.G. Paterson
Department of Educational Psychology
University of Alberta
EDMONTON

Members:

Dr. R. Ousta
Director of Guidance and Special Education
County of Red Deer
RED DEER

Mrs. Gayle James
Clinical Social Worker
Education Clinic
Edmonton Public School Board
EDMONTON

Dr. Harvey Zingle
Director of Counsellor Training Program
University of Alberta
EDMONTON

Dr. Donald Kinley
School Psychologist
Edmonton Public School Board
EDMONTON

Mr. Pat Holt
Director of Special Education
Edmonton Public School Board
EDMONTON

Relative Roles of Professional Personnel

Chairman:

Dr. K.I. Pearce, Head
Department of Psychiatry
Foothills Hospital
CALGARY

Members:

Mr. Frank Bach
Director
Catholic Family Service Bureau
CALGARY

Dr. David Gibson
Department of Psychology
The University of Calgary
CALGARY

Mr. Ralph Coombs
University of Alberta Hospital
EDMONTON

Dr. T.C. Saunders
48 Academy Medical Building
CALGARY

Research in Mental Health

Chairman:

Dr. P.O. Davidson
Department of Psychology
The University of Calgary
CALGARY

Members:

Dr. T.E. Weckowicz
Department of Psychiatry
University of Alberta
EDMONTON

Appendix 2

Dr. J.T. Hamilton, Head
Department of Psychology
University of Lethbridge
LETHBRIDGE

Dr. C.G. Costello
Department of Psychology
University of Calgary
CALGARY

Dr. J.R. Royce, Director
Centre for Advanced Study in
  Theoretical Psychology
University of Alberta
EDMONTON

Dr. Keith I. Pearce, Head
Department of Psychiatry
Foothills Hospital
CALGARY

Appendix 3

Approved and Ordered,

Grant MacEwan (signed)

Lieutenant Governor

O.C. 225/68

Edmonton, Tuesday, January 30, 1968.

The Executive Council has had under consideration the report of the Honourable the Minister of Education, dated January 25, 1968, stating that:

WHEREAS The Alberta Human Resources Research Council was appointed by Order in Council 1928/67 under authority of The Alberta Human Resources Research Council Act: and

WHEREAS it is considered desirable to conduct a comprehensive mental health study for the Province of Alberta, pursuant to section 3 of the said Act:

THEREFORE, upon the recommendation of the Honourable the Minister of Education, the Executive Council advises

1. That Dr. W.R.N. BLAIR, Head of the Department of Psychology, The University of Calgary, be and is hereby appointed director of the Alberta Mental Health Study.
2. That with respect to that study the said Dr. Blair is responsible for:
   - (a) an objective province-wide assessment of resources and evaluation of needs for maintaining mental health and treating mental illness; and
   - (b) making recommendations for the development of an improved comprehensive and integrated program for the diagnosis, treatment, care and rehabilitation of the mentally ill and for the prevention of mental illness in Alberta.
3. That the said Dr. W.R.N. Blair be and is hereby authorized to engage the services of consultants, graduate students and such other persons considered necessary to carry out the study.
4. That the said Dr. W.R.N. Blair be and is hereby authorized to incur expenses for the implementation of the said study, subject to the approval of the Executive Council.
5. That the total of all expenditures incurred for the study shall not exceed $70,000.
6. That all expenses incurred in connection with the said study be charged to Appropriation 1412.

(signed) Ernest C. Manning
Chairman

Approved and Ordered,
Grant MacEwan (signed)
Lieutenant Governor

O.C. 972/68

Edmonton, Tuesday, May 21, 1968.

Upon the recommendation of the Honourable the Acting President of the Council, dated May 17, 1968, the Executive Council advises that the Lieutenant Governor in Council hereby orders as follows:

1. DR. W.R.N. BLAIR, head of the Department of Psychology, The University of Calgary, is hereby appointed director of the ALBERTA MENTAL HEALTH STUDY.

2. With respect to that Study, the said Dr. Blair is responsible for

   (a) an objective, Province-wide assessment of resources and evaluation of needs for maintaining mental health and treating mental illness; and

   (b) making recommendations for the development of an improved, comprehensive and integrated program for the diagnosis, treatment, care and rehabilitation of the mentally ill and for the prevention of mental illness in Alberta.

3. The said Dr. Blair is authorized to engage the services of consultants, graduate students and such other persons considered necessary to carry out the Alberta Mental Health Study.

4. The said Dr. Blair is authorized to incur expenses necessary for the implementation of the Alberta Mental Health Study.

5. In lieu of payment of remuneration to the said Dr. Blair, there shall be paid to the Board of Governors of The University of Calgary the sum of $3,500 to be used for the purposes of providing scholarships or bursaries for graduate students in psychology and to be expended or applied for those purposes in accordance with the directions of the Board of Governors of The University of Calgary, in consultation with the said Dr. Blair.

6. Subsistence and travelling allowances shall be paid to Dr. Blair and to any persons engaged by Dr. Blair pursuant to paragraph 3 at the rates applicable to employees in the public service of the Province having a salary grade of Grade 34 or higher.

7. Where Dr. Blair or any person engaged by him pursuant to paragraph 3 uses a privately-owned automobile in the course of his duties in connection with the Alberta Mental Health Study, travelling allowances shall be paid therefor at the rates specified in section 3 of the Regulations in respect of Privately Owned Automobiles Used on the Business of the Government.

8. The total of all expenditures incurred for the Alberta Mental Health Study shall not exceed $70,000.

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9. All expenditures incurred in connection with the Alberta Mental Health Study shall be charged to Appropriation 2708 - Surveys and Commissions - Treasury Department.

10. For the purposes only of section 43 of The Financial Administration Act, the Alberta Mental Health Study shall be deemed to be part of the Department of Health.

11. This Order rescinds and replaces Order in Council numbered O.C. 225/68 and dated January 30, 1968.

12. This Order is effective April 1, 1968.

(signed) A.J. Hooke
Acting Chairman

Appendix 5
Chapter 1

Approved and Ordered,

Grant MacEwan (signed)

Lieutenant Governor

O.C. 2235/68

Edmonton, Tuesday, December 10, 1968.

The Executive Council has had under consideration the report of the Honourable the President of the Council, dated December 9, 1968, stating that:

WHEREAS Order in Council numbered O.C. 972/68 established terms of reference for the ALBERTA MENTAL HEALTH STUDY to be conducted by DR. W.R.N. BLAIR; and

WHEREAS clause 5 established a remuneration of $3,500 to be paid to the Board of Governors of The University of Calgary to be used for the purpose of providing scholarships or bursaries for graduate students in psychology:

THEREFORE, upon the recommendation of the Honourable the President of the Council, the Executive Council advises that Order in Council numbered O.C. 972/68 be and is hereby amended by striking out clause 5 and by substituting therefor the following:

5. In lieu of payment of remuneration to the said Dr. Blair, there should be paid to the Board of Governors of The University of Calgary the sum of $5,000 to be used to sponsor a National Conference on Behavioural Modification at Banff, Alberta.

(signed) Ernest Manning

CHAPTER 1

OBJECTIVE AND PRINCIPLES

Objective

The overall objective of a mental health program obviously must be the attainment and maintenance of a high degree of mental health. This desirable goal implies more than the control of illness to keep it at the lowest possible minimum. In more positive terms, it also implies the achievement of a level of social and personal well-being, at which a population can develop its potentialities to the fullest possible extent, relatively unimpeded by mental illness or maladaptive behavior.

We do not become mentally ill or remain mentally healthy in a social vacuum. Although we know far too little about the causes of mental illness, it is clear that powerful influences in our fast moving and rapidly changing society put obstacles in the way of productive and mentally healthy living. Such influences cannot be brought under complete control but their stressful effects can be minimized by organized and cooperative effort.

The amount of effort needed for success in mental health programs lies far beyond the scope of the so-called "health professions", like psychiatry, general medicine, nursing, social work and psychology. It commands the attention of several departments of government, other professions, notably education and the clergy, industry, social agencies in the community and the public at large. Mental health is really everybody's business because of the adverse effects of mental illness on the achievement of social and personal well-being. It cannot depend on the efforts of one department in a provincial government, alone, although strong leadership and adequate support should be expected from that quarter.

If the mental health program, which is to be proposed in this report, is to be even a modest success, active and sustained participation by a sizeable part of Alberta's society will be required. It was encouraging to note during the progress of the Alberta Mental Health Study that many of the required resources are present in the Province and they are ready and willing to be committed. They require only a plan for an integrated operation, plus leadership and support from the Government.

Principles

The following operational principles or guidelines for mental health services were determined during the course of the Study. They are presented here as a backdrop against which deficiencies in the current system and recommendations for an improved system can be viewed.

1. Because of the complexity, urgency and magnitude of mental health problems in the Province, any new system which may be adopted must make full use of available personnel and facilities.

2. Optimum use of these resources, and the need to avoid overlapping and other uneconomic activities, demands that they be designed and organized to function as an integrated system.

3. Early detection and prompt treatment, and early release and effective rehabilitation, are essential if the debilitating and often disabling effects of long stays in hospital are to be avoided. The resources in the community to meet most demands are considerable but they have to be mobilized.

4. Delegation of operational authority to community level is essential to create an integrated mental health service, which will make maximum use of local knowledge, local concern and local resources of all kinds.

5. Persons with mental illness of any kind must receive the same excellence of attention and care, as readily, as efficiently, and with as much concern shown for them as persons with any other kind of illness. In a vast majority of cases, the implication is that they should be treated without dislocation or interruption, from the point of detection through to rehabilitation, within or close to their own community.

6. Departmental responsibility for mental health should be exercised solely through planning, the development and promulgation of policy, establishment and maintenance of standards and the operation of financial controls. In assuming that responsibility it is imperative that the Department treat mental health, organizationally, functionally and financially, as an integral part of general health services.

7. The fact that people make systems and programs in mental health must be recognized. In the creation of a new system and new programs, first priority in plans, action and financial support must go to the recruitment, training and maintenance of the necessary personnel.

8. Because of the lack of scientific knowledge about mental illness, it is essential that a major effort be assigned to research of all kinds and to innovations in treatment and other programs, as suggested by the research findings. Continuous and systematic evaluation of the effectiveness of programs should be considered a normal and necessary function of any progressive mental health organization.

It will be observed that the above "principles" bear a close resemblance to the theme and major recommendations of the Committee of Psychiatric Services, which was responsible for the report More for the Mind, (1) published by the Canadian Mental Health Association in 1963. The resemblance is intentional because the Alberta Mental Health Study found substantial support for the conclusions which were advanced in that publication.

In the chapters, which follow immediately, an examination of mental health problems in Alberta, as perceived by Study Groups and research personnel, will be presented. Interwoven with their findings and identified separately will be facts and ideas submitted by consultants, research personnel and authors of briefs. In each chapter conclusions and recommendations, derived by the Director of the Study, will be recorded.

References

1. Tyhurst, J.S. *et al*: *More for the Mind*, *A Study of Psychiatric Services in Canada*, The Canadian Mental Health Association, Toronto, 1963.

CHAPTER 2

THE INCIDENCE OF MENTAL ILLNESS IN ALBERTA[1]

INTRODUCTION

This chapter summarizes some available statistics related to the incidence of mental illness in Alberta. Its purpose is to provide estimates for the number of future beds needed to accommodate patients with mental and emotional disturbances. The sources of the data are tables and statistics published by the Dominion Bureau of Statistics and the Alberta Department of Public Health, as well as articles reporting research into these problems in various parts of North America and Europe.

It is necessary to distinguish between the incidence of mental disorders and rates of hospitalized patients. While the latter may be used to generate estimates of the former, they are not the same thing. First admissions and resident patient rates have been useful indirectly for suggesting various hypotheses concerning the distribution of mental disorders (Kramer, Pollack and Redick, 1961). A point to be emphasized, however, is that mental hospital data present an incomplete picture of the number of people under treatment. The use of hospital statistics is a necessary restriction, however, since these are the only data which are available relating to the problem of the prevalence of mental disorders. In effect, the definition of incidence in this paper is restricted to the data which are available from hospital sources.

CURRENT SITUATION IN ALBERTA

In seeking information required to make the estimates spoken of above for the Province of Alberta, one is impressed with the apparent lack of systematic record keeping which would facilitate an assessment of the effectiveness of services in the mental health field. To be sure, a good amount of information is obtained from patients, families and attending physicians. Furthermore, a number of studies have been carried out in particular areas which have been aimed at examining particular aspects of mental health problems in each of these areas. Nevertheless, there is an obvious lack of current and efficient record keeping which would make cross-sectional and longitudinal studies of the mental health "delivery system" more useful and realistic endeavours. The job of assessing the effectiveness of this system is left to haphazard methods and randomly assorted studies if and when interested individuals wish to undertake them. Since the evaluation of programs apparently has been considered to be tangential to the main operation of mental health services, any predictions made on the basis of these past statistics should be made with full knowledge of their limitations.

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[1] This Chapter was based on a report by Dr. J. Edwin Boyd of the Department of Psychology, University of Calgary, a research officer with the Alberta Mental Health Study. WRNB

Summary Tables

Tables 1 to 4 present the most current data available relating to the situation in the Province of Alberta. Figures in Table 1 were derived from reports of the Alberta Public Health Division. Between the years 1961 and 1967 the population of Alberta rose, as did the number of patients in Alberta hospitals during those years. While the rate per thousand of population of patients in institutions did not change appreciably, the rate of acute illnesses decreased somewhat while the rate of chronic illness increased, as did the rate for other emotional problems and, in particular, for mental retardation.

Table 2 presents data gathered from the Dominion Bureau of Statistics. Between the years 1958 and 1964 the Alberta rate per thousand increased slightly while the Canadian rate per thousand decreased. While the basis for reporting for Table 2 is different from that of Table 1, the reported rate per thousand is still between 3.5 and 3.9 per thousand in both cases. The median length of stay in Alberta is, on the whole, very similar to that of the rest of the country. It should be noted that figures derived for length of stay using patients in hospitals are considerably larger than using patients who have been discharged during any particular year. The median length of stay for discharged patients has typically been in the vicinity of 3 to 4 months. It is clear from Table 2 that 80 to 90 months is a more appropriate median for patients who remain in hospital.

Table 3 gives some figures pertaining to admissions and discharges at Alberta hospitals. Again, the basis of reporting these figures is different from those in Tables 1 or 2. It is also clear that under re-admission for example, a change in reporting procedure occurred after 1965. These procedural changes occur frequently throughout all agencies and make comparisons rather awkward. It can be seen in Table 3 that the total number of discharges and deceased patients each year is somewhat smaller than the total number of admissions to Alberta hospitals each year. This would suggest a slow but persistent increase in long-term patients which was reflected in the increased rate per thousand of chronic patients in Table 1.

Many general hospitals in Alberta admit patients having a psychiatric diagnosis. Table 4 outlines the trends in number of cases and average length of stay for patients in general hospitals so admitted. It can be seen in this Table that the number of cases in these categories has increased steadily since 1961. In spite of this increase, however, the average number of patient days has remained relatively constant. These trends would suggest that, although more people are being seen in general hospital wards, they are not being admitted as long-stay patients.

The opening of Foothills Hospital in Calgary in 1966 provides an interesting example of the manner in which patients with psychiatric diagnoses can be handled in a general hospital setting. Over 170 patients were admitted to Foothills Hospital in 1966 having psychiatric diagnoses. Few of these patients were subsequently admitted to other long-term mental hospitals. Moreover, the net increase in psychiatric patients in Calgary was over 100 during the same year. Again it should be stressed that the increase in numbers of patients did not result in an increased length of stay per patient.

Projections for Future Needs

There are two basic approaches to the prediction of future needs: a) an actuarial basis which assumes that events will occur in the future as they have in the past, and b) a prediction based on a statement of desirable goals and consequent manipulation of the system to achieve these goals. A landmark in actuarial studies was recorded by Tooth & Brooke in 1961. These investigators were concerned with predicting the needed beds in Great Britain over a 15 year period. The formula they used predicted a decrease in beds per thousand from 3.4 to 1.8 over a ten year period. This 1.8 bed per thousand included .34 short-term beds (less than 1 year), .53 medium stay beds, (one to 2 years) and .89 long term beds.

In a study reported by Felix and Kramer (1953) the psychiatric bed rate per thousand population in the United States in 1950 was 3.8. This can be seen as very comparable to the present situation in Alberta. Since 1950, however, there have been major advances in the management of mental illness. These have been reflected in some places by decreasing emphasis on hospitalization, particularly of the long term variety, earlier and shorter treatment and the greater use of non-hospital community facilities, instead of almost total reliance on custodial care in mental hospitals. The same trends are present in very recent years in Alberta but no records are being set here. It will require much more effort, staff and imagination in new programs to offset years of lethargy.

Much has been written in recent years about the Saskatchewan mental health program (e.g. Frazier & Pokorny, 1968). This system is an example of the second method of making a prediction, namely, to decide what type of service is most appropriate and manipulate conditions to achieve that aim. Up until 1965, the rate per thousand of psychiatric beds in Saskatchewan was approximately 3.8. The current total number of approximately 1500 psychiatric beds[2] in the Province gives a rate of 1.5 per thousand. While this change was achieved rather rapidly, it is an indication that hospitalization practices can be modified according to planned changes rather than predictions made on actuarial bases. According to the most recent information, the hospital at Yorkton had been planned for 300 beds. The buildings actually constructed are 4 units of 33 beds each, making a total of 132 beds available. Reliable sources indicate that less than 60 beds have been used.[3]

A report by Kramer, Pollack and Redick to the American Psychopathological Association in 1959 examined some of the variables which may account for differences in rate of occurrence and/or hospital bed utilization for mental patients. These authors concluded that variations in the psychiatric bed rates from state to state and from time to time are more a function of differences in a number of external, environmental factors than of differences in the true incidence and prevalence of mental disorders. "More specifically, these external factors relate to such things as differences in the availability and utilization of public mental hospitals, the staffing patterns and treatment programs of the hospitals, the demographic characteristics of the community, and the attitudes of the patients' family and community toward the mentally ill." In other words, it would appear that, if more mental hospitals were built in Alberta, they would be filled. If fewer mental hospital beds were provided, more treatment would be undertaken in clinics and general hospitals, with beneficial results, particularly in terms of earlier recovery. Consequently, the adoption of an actuarial prediction model prevents the control of conditions in a more desirable fashion.

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[2] See Frazier & Pokorny, 1967.

[3] The Yorkton "catchment" area amounts to more than 90,000. Thus, a psychiatric bed/population ratio of approximately .7 per thousand, excluding retardates, has been found adequate. The comparable ratio for Alberta in 1966 was more than three times the Yorkton figure.

Based on the foregoing discussion, and recognizing the need to modify the system in a gradual manner, the following recommendations are made:

RECOMMENDATIONS

1. The Province of Alberta should not plan on increasing the number of beds for mentally ill persons. The large mental hospitals should be reduced to manageable size, while more appropriate facilities are provided in general hospitals.

   This recommendation is consistent with the findings of Tooth and Brooke, as well as experience to date within the Saskatchewan mental health system.

2. Increased use should be made of psychiatric units in general hospitals, day hospitals, out-patient departments, guidance clinics and other non-hospital facilities for the following reasons:

   a. A person is likely to stay in general hospital a shorter length of time than in a large long-term institution, and consequently institutionalization can be avoided or at least minimized.

   b. The person, whose illness is treated early and promptly within his own community, has a better chance to return to more productive living at an earlier date and with less extensive rehabilitation.

   General hospital statistics support this recommendation as opposed to major reliance on the use of the large, centralized mental institutions currently in operation. A study by Smith (1963) suggests that, with adequate staff in general hospital settings, few, if any, of the mental hospital facilities are necessary for effective service.

3. The Province should support the establishment of more community facilities to provide social services for patients and families. Patient care could then be carried out on an active community basis, rather than requiring a large number of long-term hospital beds. The provision of half-way houses, boarding homes and sheltered workshops, to mention only three possibilities, is a more effective and more economical way of achieving maximum development of people, with dignity, than the continued extension of the mental hospital system.

4. The Government of Alberta should institute and maintain a computerized information system with relation to mental health which would provide the necessary basis for sound planning and program evaluation. Adequate statistics are not available now for those purposes. Computer records are being kept in the general hospital system and most of the provincial

financial controls are on an automated basis. It is suggested that the mental health of citizens should be accorded a similar status.

5. Research is needed in force to fill the mammoth gaps in current knowledge here regarding the incidence, nature and treatment or management implications of mental illness and maladaptive behavior in the population at large.

In conclusion, it is considered appropriate to quote a paper submitted to the World Federation for Mental Health, which was published in 1967. In discussing some aspects of mental health research, the paper reads:

> "It would seem to be no more than prudent conduct, whenever social legislation is contemplated, to make provision in the legislation for evaluation and scientific control from the outset, and for a continuous program of research into ways of improving techniques and methods. It is important to ensure not only that public effort and money are being well spent, but also that research and evaluation become an integral part of social action; that the latter should no longer be regarded as an outside or luxury activity dependent on charitable foundations or the part-time services of a few interested scientists, with all the arbitrariness and lack of coordination that are likely to arise when it is so regarded."

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TABLE 1.

PATIENTS IN HOSPITAL AT YEAR END

FIGURES FROM ALBERTA PUBLIC HEALTH DIVISION[1]

		NUMBERS			RATE PER THOUSAND			
YEAR	POPULATION OF ALBERTA(Millions)	ACUTE	CHRONIC	OTHER[2]	ACUTE	CHRONIC	OTHER	TOTAL
1961	1.33	2630	741	1569	1.97	.56	1.18	3.71
1962	1.36	2561	726	1760	1.95	.53	1.30	3.78
1963	1.38	2503	721	1820	1.81	.59	1.31	3.71
1964	1.41	2509	847	1862	1.78	.60	1.43	3.81
1965	1.43	2432	937	2012	1.72	.66	1.42	3.80
1966	1.46	2282	943	2157	1.56	.64	1.47	3.67
1967	1.48	2101	927	2205	1.41	.63	1.49	3.53

1. These figures include only the institutions managed by the Province. They do not include psychiatric units of general hospitals, etc.

2. Under "other" are included special training schools, and units for emotionally disturbed children.

TABLE 2.

PATIENTS IN PSYCHIATRIC INSTITUTIONS

FIGURES REPORTED BY D.B.S. - SOME COMPARISONS

	Alberta[1]	Alberta Rate Per Thousand	Canadian Rate Per Thousand	Medium Length of Stay (Months)	
				Alberta	Canada
1958	4977	3.58	4.13	92	96
1959	4969	3.49	4.14	92	96
1960	5230	3.56	4.18	84	72
1961	5075	3.53	4.15	68	72
1962	4844	3.53	4.01	84	96
1963	5133	3.53	3.93	80	84
1964	5699	3.88	3.95	77	78

1. This is the total for groups called "Mental Hospitals", "Training Schools", "Senile Homes", and "Psychiatric Units".

TABLE 3.

ADMISSION AND DISCHARGE RATES TO ALBERTA HOSPITALS

	FIRST[1] ADMISSION	RE-ADMISSION	TOTAL[2]	DISCHARGES DEATHS
1961	1209		2312	2188
1962	1353		2601	2481
1963	1443		2835	2712
1964	1533		2998	2882
1965	1702		3487	3250
1966	1746	1726	3702	3607

1. These figures pertain to Alberta Hospitals, Edmonton and Ponoka only.

2. These figures pertain to all institutions managed by the Province.

TABLE 4.

NUMBER OF CASES AND AVERAGE STAY FOR PATIENTS HAVING PSYCHIATRIC DIAGNOSES IN GENERAL HOSPITALS[1]

	PSYCHOSES	PSYCHO-NEUROSES	BEHAVIOR DISORDERS	NUMBER OF CASES	AVERAGE NUMBER OF PATIENT DAYS
1961	1123	2840	834	4797	11.6
1962	1222	3247	894	5363	11.5
1963	1399	3723	1122	6244	11.8
1964	1735	4216	1272	7223	11.9
1965	1886	4290	1395	7571	12.0
1966	456	1064	6068	7588	11.9

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[1] These data were provided by the Hospitals Division of the Department of Public Health.

CHAPTER 3

PATIENT CARE

K.I. Pearce, M.D., Chairman
L.E. McLeod, M.D.
Miss S. Ryan B.Sc.N.

Introduction

Patient care in a sample of institutions in the Province was reviewed during June 1968. The method chosen was developed by the Canadian Council on Hospital Accreditation for use in mental hospitals. By employing that method, it was hoped the findings would be as objective as possible in relation to existing methods of measurement.

Hospital accreditation in Canada represents a joint endeavour by the Canadian Medical Association and the Canadian Hospital Association. The assessment of the degree to which any Canadian hospital meets an overall standard assists hospitals to identify those areas where performance is less than satisfactory. It also provides a general guide as to the level of the operation of the hospital and its suitability for use in professional education and training.

The accreditation process for general hospitals has become well established and is widely accepted. The standards for mental hospitals, however, were established only in 1964 and the outline used in this investigation did not appear until 1966. Both must be considered tentative because their applicability is under continuing examination. As an example, a full day's discussion of mental hospital accreditation preceded the 1968 annual meeting of the Canadian Psychiatric Association. The work of this committee, therefore, was limited not only by available time but also by the need to employ standards not yet clearly established and techniques of application which require further exploration. Despite these limitations, the committee considers that a reasonable basis for the derived conclusions was available.

The terms of reference of the committee did not clearly require detailed investigation of inadequacies, but the committee explored deficiencies, which they encountered, within the limits of the techniques available, to gain some insight into their origin.

It is pertinent to draw attention to the unique relationship between the hospital administration and the professional personnel employed within an institution, particularly in the case of the medical and nursing professions. It is clearly impractical and undesirable for members of such professions to become deeply involved in the day-to-day operation of an institution, e.g. providing food and accommodation, and ensuring cleanliness and good plant maintenance. However, the activities of the hospital administration in these general areas frequently impinge on patient care in either a beneficial or deleterious manner. An example could be the operation of the surgical suite, where the activities of housekeeping may influence the incidence of wound infections. Thus, it is the prime responsibility of the hospital administration to provide services, working in conjunction with professional personnel in the best interest of patient care. Only through cooperation of the two can the necessity for the most economical operation of an institution be reconciled with the goal of a maximum level of patient care. For this reason, much attention has been paid in hospital accreditation studies to the mechanisms by which the professional personnel of a hospital govern themselves and their activities, while interacting with the administration in the operation of pertinent committees to ensure the highest possible level of patient care within economic bounds.

The focus of this type of activity from the medical point of view is a "medical advisory committee". This body generally deals directly with the administration of the hospital, but there must also be provision for the advisory committee to deal directly on occasions with the governing body of the hospital, usually a hospital board, through what may be termed a "joint conference committee". The medical advisory committee may establish subcommittees to interact with and advise the administration. Problems, which can not be resolved at that level are usually subjects for decision at regular meetings of the medical advisory committee in conjunction with a senior level of administration . Matters, which can not be decided at those levels, may then be handled through a joint conference committee, representing the governing board and representatives of the medical advisory committee, in conjunction with members of the administration.

It has been argued that hospitals dealing directly with governmental departments are unable to meet this model of administration. This would appear untrue because no distinct differences between such hospitals and general hospitals exist except that the governing body or board of governors is replaced in governmental institutions by a divisional director or a deputy minister.

Problems of other professions, including nursing staff, social workers and psychologists, may differ somewhat in that these individuals are usually employees of the hospital; however, the basic principles remain unchanged. The need for dialogue between them and other professional people and the administration of a hospital remains as important as the dialogue, which must occur between the medical staff and the administration. The absence of structures to permit this formal dialogue generally produces a lower standard of patient care because the administration tends to be deprived of expert advice and the professional staffs work in isolation often with low morale.

In the best institutions administered by the Division of Mental Health, the committee repeatedly received complaints from professional personnel that their advice was generally ignored and that a lack of communication and wastage of already limited facilities were apparent. The importance of organization and communication are underscored by the attention paid to those subjects in hospital accreditation documents. They were important to the committee also because they involve professional personnel, programs and patient care.

Although physical facilities are of secondary importance they were also assessed in the light of their influence on patient care programs. At the accreditation meeting of the Canadian Psychiatric Association in 1968 it was concluded that mental hospital facilities require the following characteristics: safe; open; spacious, bright; provide for privacy; provide for freedom; to be non-custodial; provide ready accessibility for staff to patients and their families; and provide some control over patient movement and patient interaction.

It is against those criteria that the committee formed its opinions. During the evaluation of various hospitals, Miss Sheila Ryan concerned herself principally with nursing; Dr. McLeod with matters affecting medical care and medical staff; and Dr. Pearce with problems of psychiatric treatment programs and the employment of other professionals. The committee's report represents a collective viewpoint of the three members, to which all subscribe.

A summary of findings relating to each institution will now be presented.

ALBERTA HOSPITAL, OLIVER

Although the hospital is situated close to Edmonton, the committee was concerned by its geographic and medical isolation and felt that responsibility in part must be borne by the City of Edmonton, its other hospitals and medical institutions. The committee saw evidence of seriously overloaded facilities being further stressed by the admission of many different types of medical and social problems, which would have been better dealt with at the source or at other health care levels.

One particular problem made a deep impression and highlighted the lack of cooperation and communication between two Divisions of the Department of Health. Large numbers of alcoholics were being consigned (in June) to this understaffed and physically inadequate institution, while only one mile away the luxurious and very adequate facilities of the Alcoholism Division unit at Henwood were 90% empty and unused.

The Alberta Hospital (Oliver) suffers to a serious extent from an administrative problem found to be quite general in those institutions visited by the committee which are administered by the Division of Mental Health. The remoteness and apparent inflexibility of the central administration have produced negative effects on morale, efficiency and recruiting. In fact, the situation was sufficiently severe as to be interpreted frequently by those in the field as a lack of concern on the part of the central administration.

A nucleus of clearly dedicated staff was found at Alberta Hospital (Oliver), although smaller in relative numbers than at other institutions. The committee was concerned that these individuals were overwhelmed by the magnitude of their task. Poor physical facilities, gross staff shortages in every category, and undue service pressures within, combined with what was perceived as unfair criticism and administrative obstruction from without, had created an intolerable burden. It is clear that major remedial action is required to reinforce the staff and to lighten their impossible load.

In every area examined, other than dietary, the standard of patient care at Oliver was found to be quite unacceptable. It must be improved if it is to be considered a treatment facility. In addition, so long as it continues to provide the current quality of care, it must be considered entirely inappropriate as an educational facility. There was ample evidence to indicate that Oliver would serve only to produce a negative effect now on students in any category.

ALBERTA HOSPITAL, PONOKA

Bearing in mind the three principal limitations affecting this institution (Remoteness of administrative control, geographical isolation from principal communities served, and serious staff shortages), the committee was impressed by the standard of patient care.

In addition, high levels of morale and dedication were encountered in all staff categories. These conditions were not restricted to immediate aspects of patient care. They extended into a concern to remain abreast of the changes in the management and treatment of mental illness through in-service education, undertaken locally.

The committee concluded that, given sufficient support, this institution was strong enough to markedly upgrade the level of patient care and to deal with such lasting problems as its distance from the areas it serves and the consequent need to develop a new role beyond that of a regional mental hospital.[1]

ALBERTA HOSPITAL, CLARESHOLM

Although the physical facilities at this institution are adequate, the level of patient care is well below acceptable standards.

There is a total absence of such important health professionals as a pharmacist, a psychologist, a social worker, or a recreational or occupational therapist. The provision of medical care is little better, with two part-time general practitioners caring only for serious medical problems and a clinical director 250 miles away, who has to find time for the responsibility of his appointment from his principal commitment as Director of the Division of Mental Health.

The level of patient care at Claresholm is unsatisfactory, if for no other reason than the general acceptance there of the belief that its function is to house 400 incurables. It appeared to the committee that the conviction of incurability is based on inadequate examination, investigation and knowledge of individual patients, and a lack of acceptance of modern ideas with regard to the possibilities of at least partial rehabilitation.

ALBERTA SCHOOL HOSPITAL, RED DEER

This institution has a bed capacity of over 1,000 and is primarily intended for the long term care of mentally retarded children to age 16. It also contains a small unit, Linden House, which treats emotionally disturbed children with average or higher intelligence.

Generally, the physical facilities were found to be attractive, well maintained, and orderly.

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[1] Unfortunately there have been serious and unusual losses of professional staff since the committee's visit in June. They would have to be made up before these conclusions could apply. WRNB

There was considerable evidence that the leadership of the institution would command the respect and support of the relatives of patients.

One primary problem of the institution appears to be the lack of trained staff. There is one physician, the Medical Superintendent, who administers the institution, gives guidance and direction to all categories of staff and is involved in the program for students in the mental deficiency nursing course. He is also responsible for the emotionally disturbed children's unit at Linden House.

It was noted that patients had been very inadequately investigated on admission from a medical point of view. In addition, standards and controls in the laboratory were inadequate, although there did seem to be a good relationship with the general hospital in Red Deer, which provides most of the major medical and surgical support.

The Matron is a mental deficiency nursing graduate, who trained in this hospital. The majority of nursing care is provided by aides, attendants, and students in this program. Thus the training of mental deficiency nursing graduates is a matter of considerable importance because of the central role they have in the care of these patients.

Each year some 100 to 130 "students" are employed and enrolled in a three-year M.D.N.G. course. The training appears to have no outside recognition. The nursing supervisors, the Matron, and the Medical Superintendent constitute the teaching staff. There is only one person employed as a full-time instructor and he is a male M.D.N.G. Clearly this situation leaves a great deal to be desired and it is very difficult to see how the training as constituted can provide sufficient preparation for other than purely custodial care. It should be noted, however, that the senior staff of this institution feel neglected in that they are unable to hire adequate numbers of appropriately trained personnel. The M.D.N.G. course appears to be the best arrangement under the circumstances. It certainly reflects the energy and ingenuity of the Superintendent.

It is also apparent that the orientation and methodology of the institution should be primarily educational and psychological, with some medical support. It is believed that it should be considered a special kind of school except for its totally incapacitated patients. It is recommended that its role be redefined in these terms and that responsibility for staffing and program be assigned to the Department of Education.

GLENROSE PROVINCIAL GENERAL HOSPITAL

In this case the committee was concerned with only one unit of the handicapped children's hospital.

There was insufficient time to investigate thoroughly all the supporting services in the hospital but it was apparent that they are conducive to a high level of patient care. A well trained and enthusiastic nursing group operates the emotionally disturbed children's unit and there is excellent cooperation between that group and the administration of the hospital.

However, all levels reported problems related to divided administrative responsibilities. The unit, in June, was administratively part of the Alberta Guidance Clinic, Edmonton, which was under the operational control of the Division of Mental Health. Yet it was clearly impractical for it to operate in isolation from the rest of the provincial hospital. If it were not for the understanding and helpful attitude of the administrator of the hospital, it might well have been unable to function.

It seemed obvious that a quite straightforward problem of administrative responsibility had to be solved if the unit were to reach its full potential. There was much evidence, however, that the unit would have a very effective role in the handicapped children's hospital when the administrative problem was solved.

ROYAL ALEXANDRA HOSPITAL, EDMONTON

The psychiatric unit of this general hospital assumes the dual role of providing psychiatric services and teaching facilities in undergraduate and post-graduate psychiatry. It has a well directed and dynamic program, which makes full use of other health professionals. The standard of patient care in the unit is high.

SUMMARY OF FINDINGS

1. It is considered that a majority of the problems encountered in this examination stem directly or indirectly from an inappropriate administrative system, which is so strongly centralized that it could not respond to local problem even with an adequate budget. To make matters worse the budget is inadequate, according to the published information on the per diem costs for institutionalized patients.

2. The large patient population in governmental institutions are undergoing treatment with drugs. They also become ill and require medical or surgical attention. The committee considers that the laboratory, radiology, and general medical facilities are inadequate for an acceptable standard of care with those circumstances in mind.

3. Control and review of drug administration is inadequate when consideration is given to drug error and effects.

4. Hospitalization is usually merely a phase in mental illness. Communication must be provided, therefore, between those providing hospital care and those responsible outside for continuing care. Current communication is inadequate.

5. In no government institution did the committee find adequate numbers of sufficiently well trained personnel in any category to carry on a reasonable therapeutic program.

RECOMMENDATIONS

1. As a first priority, current suffocating pressures must be taken off the "active treatment" government hospitals, notably the Alberta Hospital, Oliver. Toward that end, it is recommended that:

    a. Admission practices be changed at once to ensure that all illness which can be treated within a general hospital receive attention there and not be allowed to become a responsibility of a mental hospital.

    b. Drug and alcohol withdrawal and detoxification be carried out in general hospitals as a widely enforced rule. Referral of acute alcoholics, in particular, to mental hospitals should stop.

    c. A concerted effort be made to reduce the present populations of mental hospitals as other more appropriate community facilities are created or developed.

    d. Staff shortages be regarded by the Government as having passed a critical point. In the interest of meeting a critical need for improved patient care it is urged that energetic and sustained recruiting efforts be undertaken to build adequate staffs and to maintain them.

2. Another basic requirement of high priority is the introduction of a new mental health organization and administrative structure. The present system is seriously inadequate. This subject was investigated by the Study Group on Organization and Administration and is discussed in another chapter. From the standpoint of this group, however, it is strongly recommended that a complete reorganization of mental health services take place promptly in the interest of patient care. It is submitted that mental health must be totally incorporated within the general health field in all respects.

3. The standard of general medical care in the mental hospitals must be greatly improved. Preventive health measures (routine chest films, Papanicolau smears, urinalyses) are required; drug controls, based on general hospital accreditation standards, should be introduced.

4. More facilities, other than "active treatment" mental hospitals, must be developed for confused, old people. The extension of facilities, such as high quality chronic nursing homes, is indicated.

5. Institutions, which are primarily educational in nature, should become the responsibility of the Department of Education, instead of the Department of Health.

6. Responsibility for recreation and education within mental hospitals should involve the Department of Youth and Recreation and the Department of Education, to whatever extent is necessary to improve upon present unsatisfactory services.

CHAPTER 4

DELIVERY SYSTEMS

The term "delivery system" is a contraction of "system for the delivery of mental health care and services".

Deficiencies in the Present System

The current delivery system is seriously deficient on a number of counts. Major deficiencies will be outlined now. They will be elaborated and others will be discussed in chapters to follow.

1. Mental health and physical health services are organized and provided separately and illogically. Contrary to the conclusions of a national Royal Commission (1964), an extensive national professional study (1963), at least one study by a committee of the Legislative Assembly (1965), and a great mass of informed opinion, the Department of Health continues to maintain an illogical division of these services. One part is under rigid, centralized government control, with a limited scope of operations; the other, under community control with necessary community involvement and a much greater capacity for the provision of necessary services.

2. The division of health services into those two parts is uneconomical, unscientific and unfair, in that it impedes the optimum use of all talent in the total delivery system; it sets aside the interrelationships of "mental" and "physical" illness, and all of their implications for the development of coordinated facilities and treatment; and it discriminates against persons who are mentally ill, tending to consign them to badly organized, crowded and understaffed mental hospitals where management and custody, rather than active treatment, are the major "services". As will be clear from the Chapter on "Patient Care", the mentally ill people of Alberta are not receiving a fair deal, in comparison with their more fortunate "physically-ill" fellow-citizens, who are treated actively and effectively in settings which are conducive to recovery.

3. The present system (See Vol. II for a detailed brief from the Division of Mental Health) has simply grown, not according to any systematic, long-range plan, not well based on reliable data concerning population trends and the incidence of illness, and not taking adequate account of the impact on the management of mental illness of drugs introduced years ago. The solution to mental health problems in Alberta for a long time has been to provide more mental hospital beds. Other possible, scientifically justifiable and socially more desirable courses of action appear to have been regarded as outside the narrow frame of reference of the Division of Mental Health. Such courses of action might have included: prevention through early detection and prompt intervention at the school age level; the maximum use of the family physician and active treatment general hospitals; and the reduction in population of the mental hospitals by making provision elsewhere for older, manageable patients and others who

should not be in active treatment mental hospitals. As a consequence of this short and narrow view of mental illness and a totally encapsulated view of mental health, Alberta's citizens are well "fixed" for mental hospital beds but they are badly off for up-to-date treatment programs for the mentally ill and for sufficient well trained staff to make the programs really active.

4. There would appear to be an almost total lack of effective, two-way communication between elements of the Department of Health (Divisions of Mental Health and Hospitals; Division of Mental Health and its field units and staffs; and Divisions of Mental Health and Alcoholism); between the Department of Health and other health-related departments and their field staffs (Education, Welfare, etc.); between the Department of Health and the communities it serves; and between government mental hospitals and medical doctors in the communities.

   A few examples will be cited. The planning of "community mental health centres" for Calgary and Lethbridge was done without sufficient discussion of local points of view; in particular, reasons for opposing views were not examined with enough care. Although there is also some support for such centres, in the view of Study members the concept is simply outmoded. Notwithstanding the expressed opposition, some persons in authority almost appear to have said, "We'll tell you what is good for you and that is what you will get."

   In addition, Grande Prairie people at two public hearings in 1968, reported dissatisfaction with lack of governmental attention to their requirements for mental health facilities and complained about lack of communication regarding any action, which might take place following a governmental investigation in 1964.

   Complaints were also received during the Study from medical practitioners regarding the lack of communication between mental hospitals and referring physicians in individual cases. The lack of information, which the physicians consider should be provided automatically, did not assist them with follow-up and after-care. One physician commented that, when he sent a patient to one mental hospital, it was like dropping him into "a deep, dark hole from which he might never escape and I wouldn't know if he did."

   During the public hearings professional members of the mental health division from hospitals described many depressing examples of one-way communication, which had done little to sustain their morale or make for efficient operations.

5. Imperfections in the current mental health program, and its organization and administration, are not due to the staffs of the governmental institutions and all were present before the current Director of the Division was appointed about two years ago. Many people have tried to make improvements within the existing system. Some examples are: a remarkably active and effective Patient's Council at Ponoka; a Sheltered Workshop (Opportunity Enterprises) which is on a paying basis after one

year of operation in Ponoka (sponsored by patients and local businessmen); the recent involvement of University of Alberta psychiatrists in the treatment program at Oliver; and the establishment of a full-time Out-Patient Department of the Alberta Hospital, Ponoka, in Calgary, for follow-up and after care of former patients. These positive developments, however, are negligible when compared with the serious, basic and numerous deficiencies. These deficiencies are resulting in a "bad name" for Alberta's health services which will make it difficult to attract and retain professional personnel of high calibre. Albertans should be deeply grateful to those who continue to serve in a poor system. But, as Walter Nagel of the Calgary Herald pointed out in a remarkably perceptive article, reprinted at Appendix 1, devotion is not enough. Government should now act to improve the current defective system and conditions of work, in the interest of people, who need help and of the professional personnel who could give it.

6. The Division of Mental Health is improperly named if functions undertaken by an organization should be related to its title. In fact, responsibility for "mental health", as broadly and properly conceived, is not assumed effectively by any existing division or department of the Government. Mental health responsibilities comprise much more than care and treatment, the current preoccupations of the Department of Health, which are not, themselves, given adequate attention. Mental health services must also involve prevention and rehabilitation, two functions which are virtually absent from the activities of any division of the Department. It is clear that the Department must free itself from its mental straitjacket and begin to be concerned with mental health in all its aspects. The terms of reference of the Alberta Mental Health Study, announced by the Premier and the Minister of Health in November 1967 (See Chapter 1), indicate that the climate for change is right and the time for change is now.

The New System

The delivery system which is proposed for introduction in Alberta, comprises elements and functions to be described in this Chapter. It has been organized into what will be called echelons of care and service. The first three echelons are intended to lead, through truly active treatment and the least possible use of hospitalization, to rehabilitation in terms of reduced illness and more productive lives. The fourth echelon is a terminal stage where, because of age or chronic disability, recovery cannot be the aim. Provision of long term, sympathetic and entirely adequate care, in comfortable surroundings, is the requirement.

A brief outline of the four echelons follows.

ECHELON	ELEMENTS	FUNCTION
First	Non-hospital community facilities (e.g. school system, guidance clinics, family physicians, health units, social services).	Detection, diagnosis, educational and psychological treatment; medical treatment.
Second	Active treatment general hospitals, Special hospitals (e.g. emotionally disturbed children).	Short term, active treatment and follow-up of all except "security" cases.
Third	Auxiliary hospitals, Regional mental hospitals (3).	Longer term, special treatment or care.
Fourth	Nursing homes, Boarding homes, Special homes for senile or disturbed but manageable aged persons.	Long term care of high quality.

Before considering the four echelons of care it should be noted that they begin where preventive efforts have failed. Prevention will be discussed in later chapters.

First Echelon

Elements of the first echelon are: specialists in the school system (teachers, school nurses and doctors, guidance counsellors, school psychologists and others in pupil personnel services); Medical Officers of Health and personnel of health units; social agencies; the clergy; Provincial Guidance Clinics; and the family physician, who will be asked to play a key role in the system.

Functions to be undertaken at this echelon include: early detection of mental disturbance and maladaptive behavior; diagnosis and the direction of each person to appropriate attention or care; psychological first aid and emotional support for the less disturbed; social intervention, modification or help by social agencies, to whatever extent may be possible and acceptable; behavior therapy and other treatment, often psychological or educational in nature, and not requiring hospital services or residential facilities; medical examination and home or office treatment or care by the family physician and, finally, rehabilitation by way of special agencies developed by local and regional authorities with Provincial Government support.

The family physicians are on record as ready and willing participants in this plan through the brief of their College, which appears in a later chapter. The brief outlines the functions of the family physician in mental health, as perceived by the College, as follows: preventive, educational, and diagnostic services; continuous care of the less seriously disabled in the community; administrative and joint care, in specific cases, with a psychiatrist; continuous care of persons requiring long term attention in nursing homes, chronic care institutions and in their homes or other homes; care of persons with mental health problems in the general wards of hospitals and in psychiatric units; liaison with community services in the field of mental health care.

The new delivery system would require increased provision of specialists for the school system. Because resources in that field are not universally regarded as contributing significantly to mental health, and because they are part of the first line of attack on mental illness, a separate chapter will be devoted to the subject.

Guidance Clinics are also considered to be an important non-hospital, non-residential facility. One should be located in each of the proposed health regions.

A hospital should be considered only one kind of facility in the delivery system. Its resources should be invoked when other early-detection, treatment and modification facilities are immediately inappropriate or inadequate. The objective in mental health, however, should be to avoid hospitalization by making maximum use of other options, on the grounds that it is in the interest of a disturbed person to return him to active living quickly and to prevent him from slipping further down the line toward longer term care and, possibly, institutionalization.

The functions of Guidance Clinics require periodic review and change. As the school system develops its pupil personnel services, the Clinics should withdraw gradually from the educational-support field (pupil evaluation and classification) and assign more emphasis to diagnosis, therapy and follow-up in the case of emotionally disturbed people. It is probable that they should always assign a major part of their efforts to children. However, there is a need for attention to adults, who do not wish to go to hospital or do not need to do so, even on an out-patient basis. The Clinics should become increasingly involved with that group.

The peculiar approach of the Department of Health to alcoholism requires examination in this context, too. Alcoholism Clinics and Guidance Clinics might be combined, in the interest of making the best use of professional personnel and physical facilities.

In addition, the coordination of the work of health unit personnel with that of both kinds of clinics is essential. In part, this coordination could be achieved through local and regional boards. It could be facilitated to an even greater extent by putting both clinics and the health unit "under one roof", at least physically. The possibility of a closer affiliation, organizationally, also should be considered. Readers, who are aware of the Department of Welfare's activities in health-related fields, may wish to carry this reorganization one step further and that would make good sense.

Another element of great importance to success at the first three echelons of care is the health unit. Several Medical Officers of Health and Public Health Nurses presented written or verbal briefs to the Alberta Mental Health Study indicating their readiness to contribute to mental health programs. The briefs will be published in

Volume II of this report. One, from Dr. J.B. Newton, of the Leduc-Strathcona Health Unit, was typical in pointing out how natural it would be to make greater use of health units in mental health programs, particularly in after care. He also voiced the common complaint that communication now between mental hospitals, physicians, health units and other agencies in the community is quite inadequate. He stated in part: "If your committee achieved no more than breaking down some of the communication barriers in Alberta's mental health work, we will have achieved a considerable step forward."

Miss M. Middleton, Senior Public Health Nurse of the Medicine Hat Unit commented along similar lines, as follows: "Public Health Nurses believe that they give good service in the follow-up of the tuberculosis patient so that he, his family and the community benefit. They also believe that, with proper guidance, they could give similarly good service in the follow-up of the mentally ill."

A brief from the Victorian Order of Nurses (VON) will be presented in its entirety in Volume II. In summary here, the following quotes may be noted:

"The Victorian Order accepts a responsibility to assist with the development of improved mental health services in Alberta."

"The Order will provide nursing services to mentally ill patients in the present branches and will extend boundaries and services to other communities to meet needs."

" If payment for service to the mentally ill patients were included in the Alberta Health Plan more patients would be willing to receive care at home when this is feasible. Through the regular Victorian Order programs and through participation in coordinated home care programs, such as are carried out in other provinces, it has been demonstrated that a number of psychiatric patients can be successfully rehabilitated at home."

The third of the V.O.N. statements is highly relevant to improvements in the delivery system in Alberta. The notion that a hospital is the only place for mentally disturbed individuals must be dismissed if maximum resources are to be brought to bear on the problem of mental illness and if optimum results are to be obtained from any delivery system. Home care, making use of the V.O.N. and other similar personnel, is an obvious option in many cases to hospitalization and, with proper controls, it can be both economic and satisfactory. Encouragement of the V.O.N., through support from the Government, is unquestionably in the best interest of establishing a more effective delivery system.

Second Echelon

1. Active Treatment General Hospitals

Problems, which can not be sorted out at the first echelon of care, according to this plan, would be referred by the family physician to the nearest active treatment general hospital with a psychiatric unit. It is proposed, in support of a recommendation from the Alberta Medical Profession, that all active treatment general hospitals with 100 beds or more be required to establish a psychiatric unit amounting to 10 per cent of the beds as a condition for accreditation. The Profession's brief is at Appendix 2 to this Chapter.

Out-patient treatment at the general hospital would suffice in many cases: in-hospital day treatment might be necessary in others; some would need short-term, intensive treatment as patients in the hospital. The family physician would admit his patients and treat them in the majority of cases, as with other illnesses, with psychiatric consultation as required. He would also constitute the necessary link with rehabilitation, an aspect of the current system which is quite unsatisfactory now, according to briefs and statements received during the Study.

The plan for the use of active treatment general hospitals, instead of the present mental hospitals, as the basic facility for the mentally ill, emerged with strong support from primary interest groups, including The Alberta Medical Profession; the College of Family Physicians, Alberta Chapter; The Alberta Hospital Association; and the many professional and lay personnel, who participated in the Alberta Mental Health Study. It was supported in specific terms by many briefs, letters and personal appearances at public hearings throughout the Province. The proposed involvement of the family physician as a vital resource person in the management and treatment of mental illness similarly met with widespread support.

The active treatment general hospital would receive persons with any kind of mental illness, at least in its initial stages, including alcoholism, but excluding those few persons who require special security arrangements. Acute alcoholics would be admitted for detoxification and then would be referred to health units, clinics or agencies for follow-up. Persons, who are diagnosed as psychotic by reason of alcoholism, would be directed to a regional mental hospital, like the Alberta Hospital, Ponoka or Alberta Hospital, Edmonton. Forensic cases would not be admitted to active treatment general hospitals but would receive attention, on remand, at detention centres, as proposed in the Report of the Alberta Penology Study (1968) or, on Lieutenant-Governor's warrants, at regional mental hospitals.

An important requirement in the proposed delivery system is a psychiatrist functioning as a consultant to the family physician and others engaged in treatment. This concept is a departure from the customary one-to-one relationship with patients which many psychiatrists favour. It is a necessary departure, at least for some psychiatrists, however, if the skills of a very restricted number of professionals are to be made available to a large number of people who need specialized attention. The concept has the support of the Alberta Medical Profession, including psychiatrists, of course, and was strongly advocated by consultants and participants in the Study, two of whom are heads of the Departments of Psychiatry at the Universities of Alberta and Calgary.

In any "large" hospital, where the demand for psychiatric services would be heavy, there should be a Chief of Psychiatry, who would devote a specified minimum of his time to hospital practice. (The actual size and amount of time could be determined in consultation with the appropriate medical associations.) This latter provision is considered essential if adequate psychiatric leadership in treatment programs undertaken in large hospitals is to be available. Smaller demands could be met by visiting consultants who could be Public Service psychiatrists in every health region. The latter could function as consultants, on a fee-for-service basis, to the family physician generally and in relation to patients in active treatment general hospitals, in particular.

The concept of the active treatment general hospital as a primary base for the treatment of mental illness is elaborated in Chapter 9. The text is taken from the brief submitted by the Lethbridge Municipal Hospital Board which has a long-standing requirement for improved facilities.

2. Special Hospitals or Facilities

Special provisions are required for emotionally disturbed children and adolescents and for intellectually and neurologically handicapped persons. Both classes were given particular attention by the Alberta Mental Health Study in the assignments of two study groups. The findings and recommendations of the study groups will constitute separate chapters in this report. In addition, summaries or complete briefs from the Alberta Association for Retarded Children, Parents of Autistic Children, the Edmonton Social Planning Council, and other interested associations and persons will be published in Volume II of this report.

Two general conclusions may be offered now:

a. There is insufficient information about the incidence and types of problems under discussion to permit accurate planning of programs, staff and facilities. An urgent need for mental health research in this Province is emphasized.

b. The limited information available indicates that specialized treatment centres, group homes and foster homes for emotionally disturbed, neurologically and intellectually handicapped children are quite insufficient and distinctly inadequate to meet the need. This report will recommend that immediate action be taken, on the best information available, to provide more facilities, while longer term studies are in progress.

It should be noted that there is an unusual opportunity for progressive action in Calgary at this time because of the early state of the health sciences complex at the Foothills site; a new medical school; a new Vocational Rehabilitation and Research Institute associated with the University; a hospital for children; a cooperative school system; a School of Social Welfare; developing basic and graduate programs for family physicians; and departments of psychology and educational psychology with mental health interests and competence. The community, with proper coordination locally and with support from the Government, could develop a model grouping of mental health facilities and the most advanced program anywhere.

Third Echelon

The function at this echelon is treatment, which is longer in term than can be permitted in a short term active treatment general hospital for reasons of efficiency and economy. It is still "active" treatment and must be considered and conducted from that point of view. The facilities at this echelon are: auxiliary hospitals, regional mental hospitals and longer-term facilities for children and adolescents. It does not include terminal or chronic institutions.

Auxiliary Hospitals

In keeping with the principle of equality of treatment for persons with any illness, it is proposed that auxiliary hospitals accept and provide the limited treatment and the care necessary to assist patients to recover from mental illness within, or close to, their own communities. The notion that "mental patients" generally can not be accommodated in auxiliary hospitals, or should not be accommodated there, as one health official has suggested, is regarded as arrant nonsense in a day when most mental illness is manageable. In those special cases, where management is a problem, however, the regional mental hospital must be available.

Use of the auxiliary hospital for longer recovery is necessary if active treatment general hospitals are to be kept active and short term. The back-up of longer-term patients into the short stay hospital is already threatening to reduce their effectiveness and must be corrected. Corrective action should be directed primarily to the fourth echelon of care, nursing homes and boarding homes. Greatly increased facilities, perhaps largely in the boarding home field, at that echelon, are a matter of high priority if this delivery system is to work, if active hospitals are to become or remain active and if older or disabled persons are to receive the attention and care which is an obligation of their society.

Regional Mental Hospitals

This term is used to refer to Oliver and Ponoka, primarily, but also to Claresholm to some extent. It is unfortunate that population movement has made the placement of the first two less than strategic in recent years. But they are there; they can serve as good regional facilities; they are still highly essential in any delivery system; so, the only task is to integrate them into a new system. Claresholm could be used to offset, to some extent, the facts of geography and population trends, at least for the present.

However, let it be clearly understood now that the Alberta Mental Health Study does not recommend the construction of another mental hospital anywhere in the Province, now (1969), next year (1970), or in the foreseeable future. This unequivocal position applies to mental hospitals under any name, "community mental health centres" or any other.

It is based on the following facts:

1. The priority needs within Alberta in the mental health field would not be met by building more mental hospitals. First priority must be assigned to engaging and maintaining the high calibre health professionals and managers, who are needed to initiate and run new programs and administrative systems. Reference here is made to programs of all kinds (detection, treatment, rehabilitation and prevention).

2. In the interest of equalizing the treatment of all people, who become ill, regardless of reason or diagnosis, vast improvements in all existing mental health services must be achieved. That higher priority also would not be met by building mental hospitals. It can and should be met, at least in part, by creating wards, wings, or buildings in current active treatment general hospital settings, under the same local control, with mental illness treated within the community in the same manner as any other illness.

3. A priority, which also takes precedence over building any more mental hospitals, is the establishment of more auxiliary hospitals; more nursing homes; special "nursing" homes for senile, confused persons; and boarding homes, all intended to reverse the current trend within the whole system which could render the general hospitals inactive.

4. High in the list of priorities is the development of community facilities for early detection, prevention and rehabilitation. Without them functioning in a coordinated manner, no delivery system will work. Funds and leadership are needed to put them on a working basis.

5. Closely related to No. 4 is a priority which many readers might wish to give first place. It is the need to get many people out of mental hospitals. It is estimated that at least one-quarter of those in Claresholm, a chronic "hospital", could be released if they had some place to go. Many "burned-out" psychotics are receiving only welfare or custodial care and do not have to be in hospital. Community facilities must be prepared, however, as a first step to their release and then a professional survey should take place to decide upon release and placement elsewhere.

When all of the five "higher priorities" above have have been attended to, it might be time to consider another mental hospital. By that time, presumably, some systematic action could be expected in relation to the long-term determination of needs and the evaluation of programs. It is considered highly improbable now but is possible that the Province may require more long-term-care facilities, which might dictate the building of another mental hospital some time. Until that fact has been established, however, the other priorities should be pursued. Enthusiastic proponents of mental hospitals, under any name, meanwhile can take comfort in knowing that Alberta already has more mental hospital beds per thousand of population than any other province and is among the "leaders" anywhere. Even with a temporary moratorium on new mental hospital buildings (not necessary improvements or necessary replacements), it would take other places some time to overtake Alberta and equal that dubious distinction.

Mental hospital beds per thousand of population by province are reported by the Dominion Bureau of Statistics (1966) as follows: Alberta 4.1; British Columbia 3.5; Saskatchewan 3.3; Manitoba 3.4; Ontario 3.5; Quebec 3.4; Nova Scotia 3.4; New Brunswick 3.4; Prince Edward Island 3.7; Newfoundland 1.8. It is of interest to note that Frazier and Pokorny (1968) urged the Saskatchewan Government to suspend further construction in the same context until a personnel crisis was resolved and even then they assigned additional facilities a secondary priority. As indicated in Chapters 3,6,7,12,13 & 15, Alberta has a personnel crisis, too, one which is more severe because of years of neglect.

Although there is strong general support for a stop to the building of more mental hospitals now agreement is not universal. The following letter was received December 12, 1968 from eleven psychiatrists in Calgary, under the letterhead of Dr. K.R. Etzkorn, with his signature and the others:

"Dear Dr. Blair:

Re: The Alberta Mental Health Centre
Calgary, Alberta

I am writing in regard to the above mentioned treatment unit which has been proposed and planned for by the Department of Health of the Province of Alberta over the past few years. It was our understanding that further progress toward construction of this unit has been delayed until results of your study have been presented to the Government and studied by them. It is our concern that possibly this project may be shelved completely as an economic measure (1) on the basis that it is felt such a unit serves no purpose in psychiatric treatment locally (2) on the philosophy that all psychiatric treatment can be carried out in the psychiatric wings of General Hospitals. It is the opinion of the undersigned group of psychiatrists that, although we basically believe in the philosophy of treatment being carried on primarily in psychiatric wards of General Hospitals, there is a place for an integrated treatment centre such as the above proposed unit for the active treatment of types of mental and emotional illness which require a longer period of stay than is possible in a psychiatric ward. There is also need of a more structured treatment setting to effectively treat some of the more seriously disturbed individuals. We felt that it would be important for you to be aware of this opinion in preparing your brief for presentation. If there are any further questions or concerns you have about our submission please feel free to contact me.

Yours sincerely,"

The above letter also supports the use of active treatment general hospitals as the basic care facility in mental health. Moreover, readers will have observed that regional mental hospitals are a part of the proposed echelons of care. If there is any disagreement, it relates to the number of mental hospitals required to serve the population now and in the foreseeable future. As stated above, in the judgment of those connected with the Alberta Mental Health Study, the Province already has more long-term mental hospital beds than required if the facilities were put to proper use. Another mental hospital, for longer-term patients, simply is not required now and may never be required.

Many similar views were expressed in briefs and at public hearings. One letter from the president of a medical staff will serve as an illustration. (Appendix 3).

The above discussion must not obscure the fact that regional mental hospitals are necessary and will be necessary for many years. Housed in those institutions now are hundreds of people, who reflect inadequate knowledge regarding the management and treatment of mental illness; and that is one deficiency which is universal. Some probably will never be released. They may be transferred to a chronic, terminal institution but the hope of any kind of rehabilitation is dim. They represent what Frazier and Pokorny (1968; 15) called "a hard-core residual group" in reference to the Weyburn Hospital in Saskatchewan. The two consultants went on to say "....it is no reflection on the institution if fewer and fewer of these can be appropriately released, especially with the present community care facilities and staff." (It is interesting to note, however, that the patient population at Weyburn had already been reduced, by design, from 1724 in 1956 to 443 in 1967. Meanwhile, more than double the number of persons were being treated in clinics in 1967 as compared with 1956.)

Apart from a need to attend to the "hard-core", provision must be made for future treatment failures from other parts of the delivery system and for persons who require protection or special security arrangements, while on remand or Lieutenant-Governor's warrants. In addition, problem cases, who cannot be managed in clinics, general hospitals or special hospitals will still be encountered. The psychotic alcoholic will also need attention and any other elements of the delivery system would be the wrong place for him. Regional mental hospitals are needed for all cases mentioned above and no substitute for them is in sight.

Health professionals on the staff of the regional mental hospitals could be used as consultants to general hospitals and clinics in their region, if their work loads were brought to reasonable levels. In addition, the regional mental hospital should serve as an active treatment facility for physicians and hospitals without easy access to psychiatric units. Thus, there is a continuing, essential and challenging role for the present hospitals at Oliver and Ponoka. The hospital at Claresholm, with psychiatric consultation provided from Calgary and Lethbridge and a regular staff physician could also provide active treatment. In addition, Claresholm might undertake a rehabilitation role for Ponoka and, possibly, for Oliver because of its close contact with its community and its appropriate facilities.

Oliver's usefulness might be increased by assigning to it the facility at Henwood which is being used as a kind of treatment centre for selected alcoholics. The program there appears to have a shallow scientific base, little professional direction and limited promise, in terms of cure or modification of deviant behavior. Meanwhile, priority requirements build up in other health areas, where the pay-off is known to be much greater. It is considered that the facility could become a treatment and research centre for emotionally disturbed adolescents under the same clinical and administrative structure as Oliver and associated with the University of Alberta.

The patient population at both Ponoka and Oliver should be reduced sharply. Efforts have begun along those lines and showed some success in recent years. They should be intensified.

Acute alcoholics should not be admitted to either hospital in future. Manageable geriatric cases should go to special government nursing homes or approved boarding homes, as soon as they can be built or approved. Persons with physical illnesses, who are disturbed but manageable, should not be sent there. A much more selective admission policy must be applied by the superintendents, with departmental backing and with the understanding of other community institutions, physicians and the police. Energetic and sustained effort must be directed toward making both institutions truly active treatment hospitals, of a highly specialized variety. Claresholm can be more effectively used along similar lines, but more gradually as its geriatric patients are placed elsewhere.

It is emphasized, however, that the identification or development of such community facilities as nursing, foster and boarding homes, must precede substantial reductions in mental hospital populations. In addition, criteria for release have to be worked out carefully. It will be obvious that half-way houses provide opportunities for the evaluation of probable performance and adjustment, in the case of those under consideration for return to work, and that behavioral evidence, in contrast with subjective judgements, is preferable.

No mention has been made of the other chronic "hospitals", Raymond and Rosehaven, because they are essentially a special kind of nursing home for "burned-out" psychotics. Notwithstanding the hard-working and sympathetic staff, the obvious emphasis on cleanliness and good care, Rosehaven is not a place to which a visitor would like to return as a "patient." The old building, in which many patients are housed, pending the construction of what will be excellent accommodation, should be abandoned at the earliest possible time. The elderly deserve a much better fate than to finish their lives in the old Rosehaven.

Fourth Echelon

Reference has already been made several times to the components of this echelon, nursing and boarding homes of all kinds. It is stressed that these facilities must be increased greatly if the whole delivery system is to work. They should share top priority with general hospital facilities, where any construction is involved. Sufficient demographic data must be available to the Government somewhere to get along with necessary plans and construction.

The selection of boarding homes requires a good knowledge of many communities. That knowledge can be produced by the cooperative efforts of agencies and organizations within the communities; for example, the Farm Women's Union of Alberta with some 20,000 "units" are ready to place their considerable resources in support of action to improve mental health in the Province. The Canadian Mental Health Association also has been ready for a long time. (See their brief in Vol. II.) It is suggested that the C.M.H.A. be engaged on contract by the Government to survey and catalogue community facilities, in cooperation with all voluntary associations, with the objective of moving many people out of mental hospitals into fuller, more human living. It is of at least incidental interest to know that it would be possible to improve the lot of many, who are in mental hospitals, and maintain them in approved boarding homes at no more cost than their maintenance in hospital.

Rehabilitation

At each of the first three echelons, rehabilitation must constitute an integral part of the program. Comments made earlier about health units and the V.O.N. apply with equal force throughout those echelons of care.

In addition, other means must be developed to facilitate the recovery of persons who have been ill. Opportunity Enterprises at Ponoka is a good example of what can be done to provide experience outside of hospitals during the period of transition from patient to a fuller and more productive life. Sheltered workshops, or similar devices, are necessary but, as indicated in their brief at Appendix 4, they need help from government.

Similarly, half-way houses or boarding homes are required to help acquaint certain former patients with a new or forgotten way of life in easy stages. There is room for much experimentation and innovation in this field. Coordinated efforts at community level are essential and some government leadership and sponsorship unquestionably are indicated.

Coordination

The need for coordination of efforts within each echelon, between each echelon, all others, and the Provincial Government must be clear. All four echelons, with the headquarters, comprise a total delivery system. Inadequacies at any echelon will impair the operation of the system. Poor communication similarly would hinder effective operations. A tentative plan for coordination will be advanced in the next Chapter - Organization and Administration.

Coordination of certain health services at regional levels might be assigned as a responsibility to Medical Officers of Health. Guidance Clinics (including a service for drug and alcohol addicts) and welfare units should be much more closely integrated with health units on a regional basis.

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Appendix 1
Chapter 4

Revitalizing Alberta's Mental Health Programs

Walter Nagel
Herald Magazine Friday Nov. 22, 1968

ALBERTA MENTAL HEALTH STUDY

Appendix 1
Chapter 4

Dedication Is Not Enough

They were the archetypes of the successful young couple from next door: the man was tall, healthy and successful in his profession; the woman pretty, tastefully dressed, intelligent and attentive to his remarks.

But his flat, emotion-choked tones--and his wife's quick, nervous puffs at a succession of cigarettes--told profoundly more than the actual words how much their child's mental disease had gnawed away a family's happiness.

The tall man grasped the lectern so strongly his knuckles turned white. Then he turned to his audience of about 100 fellow-Calgarians and, his voice now husky with the struggle for self-control, told them his son may already have passed beyond the point of realistic hopes for recovery.

For several seconds, the room was silenced by the impact of his statement.

Partly through indifference, a world technology which already transplants living organs and may soon fling a man around the moon still recoils, in hopelessness and a sort of horror, at the spectre of mental illness.

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As his father explained, help may come too late for this youngster, a tragic loser in the "genetic lottery" played by all of humanity. But because his parents had the courage to tell their story in public, something may be done for others who face the same situation in years to come.

Headed by a Calgary psychologist, a special commission last month listened to this account and a dozen others just as touching, sprinkled through extensive discussions on ways to revitalize mental health programs within Alberta.

Transplants of new resources, new brains and new enthusiasm, in ascending order, are the province's most urgent future needs in psychiatric medicine.

The first study of its kind, the inquiry appears destined for a major policy influence upon a government which has shown an increasing regard in the past few years for Alberta's "human resource" component.

Dr. W.R.N. Blair, head of the University of Calgary psychology department and a nationally-known consultant and research worker in his field, was selected a year ago to head the $70,000 inquiry.

It is likely the commission will complete its review and preparation of a report to government by the end of this year--less than two months from now. After that, there are expectations the provincial health department will present the document to the Legislature and release it to the general public.

Already emerging as major requests from individual citizens and professional groups dealing with psychiatry are numerous requests for more local control of mental hospitals, greater expenditures of funds--particularly for manpower and research--and a renewed enthusiasm and leadership from the highest governmental levels on down.

Sentiment seems to be increasing that dedication alone--still found abundantly in provincial mental health services despite often-adverse working conditions--is not sufficient to assure good patient care.

It seems almost certain many of these opinions will be endorsed by the Blair commission.

Late last month, professional fact-finding groups reviewed special research projects done at the request of Dr. Blair. It is significant that dozens of such highly-qualified persons, many of them individually spending hundreds of hours on the special study project, have agreed to contribute their efforts without charge. Dr. Blair has asked his own honorarium be given to the University of Calgary for additional work in mental health.

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More local autonomy in psychiatric programs and the direction of treatment institutions has been in the forefront of many submissions brought before the commission.

But one of Canada's most highly respected psychiatrists pointed out at one hearing that local control, by itself, is no panacea for pyramiding bureaucracy, remoteness and finally indifference that all too often now robs centralized mental health programs of their essential vitality.

Dr. R.O. Jones of Halifax, recounting experience in his own province, told one hearing in Calgary what can happen when psychiatry is exposed to the pork-barrel philosophies of local politicking.

Under municipal jurisdiction, Nova Scotia's mental health programs and institutions fell into a shameful state, the former president of the Canadian Medical Association reported.

Capitalizing on the tax-saving sentiment in their home communities, local public officials cut mental health spending to the bone. Funds dried up, the best personnel went elsewhere, treatment centres deteriorated.

Mental patients are hardly noted for being able to complain effectively about the care they get, and public indifference allowed the adverse trend to continue for years.

Recently, however, a return to a high degree of provincial control has helped Nova Scotia bring its services back to an acceptable and still-improving level.

In a cost-cutting situation, treatment methods--and the manpower to put them to use--are likely to be the first casualties. With the disappearance of these factors in patient care goes much of the hope a mentally-ill person can regain a normal place in community life.

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Research--the pointer toward new types of treatment which can reclaim many formerly "hopeless" cases--dwindles to the vanishing point.

Psychiatric care then becomes custody-oriented, the Canadian Mental Health Association repeatedly has pointed out to the commission.

Except for the ill, their immediate family and friends, most of the population becomes content with merely keeping those who become sick out of public view and general circulation.

Only when institutions become so overcrowded that admittance must be curtailed or discharges speeded-up regardless of patients' condition does the public get any chance for insight. Often an outcry that "they" should do something only comes after a tragic incident.

Something like that seems to have been the unfortunate experience in Saskatchewan, a province heavily criticized this spring in a consultants' report to government.

Once considered among the best in North America, mental health services there regressed under wide-scale provincial cost paring, a research team from Texas pointed out.

(It's well worth pondering that Alberta's programs might have come under even heavier criticism than they did, had not some outstanding psychiatric personnel come here during the past few years as the sister province's once-attractive situation worsened.)

Some comments about Saskatchewan, by Dr. Shervert H. Frazier and Dr. A.D. Pokorny, have a striking relevance for Alberta as well:

"One of the most important recent influences has been a gradual financial squeeze...

"Salaries have fallen behind, and the leaders of the program began to leave.

"The province has gradually drifted into a situation in which it is trying to run a first-rate program on a second-rate budget, and this simply will not work.

"At the present time, the personnel situation is of crisis proportions, and must be given first priority.

"Unfortunately, it is possible to operate a large institution with sub-standard staffing. The resulting conditions may be terrible but the entire operation is out of sight and therefore may be tolerated."

There are encouraging signs the Alberta government is aware of that danger. Worthy efforts have been made to improve facilities in two gigantic mental hospitals which are pivot points of current treatment. There are signs of an increasing hesitance about building more like them--perhaps born in part from vigorous protests put forth by the CMHA and groups of professionals in the health field.

Instead, there are indications truly effective mental health care will in future make minimum use of any institution. Patients who do require specialized care will get it--perhaps during an overnight or weekend stay--at a community general hospital.

More effective screening, among patients who do require in-hospital treatment, will separate those who are mentally ill from cases of simple senility, the criminally insane, adolescents with severe behavior disorders or alcoholics, drug addicts and tuberculosis sanitorium runaways.

Armed with new drugs and techniques being found by the dozens every year, family doctors and a hopefully-much-larger group of allied health workers will deal with most mild types of mental upset. In situations beyond their immediate scope, scarce psychiatrists and psychologists will be available as professional consultants, not just as therapists.

Using facilities and personnel in their own communities, patients will be spared the lengthy disruptions which made their re-entry into normal life routines so difficult in the past.

Government's role may fall increasingly in the area of standard-setting, with greater emphasis on inspiration for achievement in mental health, and less stress upon guidance by decree.

Perhaps the very existence of the Blair commission is a sign the province--still governed by the realities of financial priorities and manpower availability--is moving toward such goals.

Dr. Blair himself may have picked up a spirit of optimism from the fact an open discussion and questioning is taking place.

"I think the climate for change is good," he told those attending one hearing. "The government itself has sought comment from a completely independent body."

"The fact the study was even established can be taken as an expression of government interest."

The Medical Profession of Alberta

Executive Director,
R. Woolstencroft, M.R.C.S.

ALBERTA MENTAL HEALTH STUDY

INTRODUCTION

We, the Medical Profession of Alberta, propose to confine ourselves generally to a statement of principles. Detailed communications, submitted by members of the Profession, are presented as an appendix.

SINGLE STANDARD OF CARE

The first principle of our brief is that all psychiatric patients, including not only children, students and mature adults, who are suffering from overt psychiatric illness, but those who by virtue of disorders of behavior such as alcoholism and drug addiction, demonstrate that they are psychologically disordered, should be offered the same standards of care as those suffering from any other form of illness.

ORGANIZATION OF FACILITIES

The responsibility for the coordination of psychiatric facilities and services should, as far as possible, exist at the local level. The responsibility of the Provincial Government should be confined to providing financial assistance, collecting up-to-date statistical information, and setting minimum standards. As far as possible, existing bodies concerned with the provision of facilities for patients should be utilized for the task of coordination of psychiatric services within the area, and where such bodies do not exist or are not suitable for this purpose, coordinating instruments should be brought into being so that the community possesses the full spectrum of preventive, diagnostic, and treatment services for all patients, regardless of the type of illness from which they suffer. It is expected that general hospitals in the various regions will, to a greater or lesser extent, make provision for inpatient services. It is recommended that 10 percent of the total bed capacity of these hospitals should be provided for inpatient psychiatric services as a prerequisite for accreditation. It is expected that the role of existing Mental Hospitals will change as the reforms envisaged make themselves felt. In order that they may flexibly adapt to changing circumstances and fit in with the normal style of hospital organization, they should be governed by Boards, members of which, should be selected from the local community or from the Boards of nearby General Hospitals.

FORENSIC PSYCHIATRY

Patients who are confined because they have committed or are accused of committing some unlawful act interfere with the program of treatment of other psychiatric patients not requiring a lock or key, and should be managed and investigated in a specially built hospital. This could be built near and staffed by a university facility, research and treatment being emphasized, and the punitive aspects of the incarceration of the patient reduced to a minimum.

MENTAL RETARDATION

The field of mental retardation is one in which many improvements could be made particularly in regard to the facilities provided and the co-ordination of treatment. We generally endorse the briefs prepared by Dr. L.J. leVann and the Alberta Paediatric Society attached in the appendix.

STAFFING AND RECRUITMENT

Both the public and physicians recognize that the pattern for the provision of psychiatric services is changing. Psychiatrists are acting more as consultants and less as individual therapists, and acknowledge this evolution. As well as the incorporation of General Practitioners as key personnel in the management of psychiatric patients, demands will be made on nurses and other paramedical personnel. These changes call for alterations in the training offered to students, and supplemental training for those already in practice. Even if optimal performance from all personnel were to be immediately achieved, the Province would still find itself drastically short of appropriately trained personnel. Therefore, incentives for the practice of psychiatry and its associated disciplines should be provided up to whatever level proves necessary, whether these be financial or in the form of the provision of facilities, or both.

RESEARCH

Compared with their colleagues in other branches of medicine, psychiatrists possess a small body of knowledge about the illnesses they treat. It follows that this is an area in which a greater proportion of medical research monies should be spent, bearing in mind the large number of people who suffer from psychiatric illness. Much of present-day psychiatric research is concerned with the formulating of plausible hypotheses based on clinical observation rather than the more elegant experimental testing of established hypotheses upon which advanced disciplines can concentrate. Thus psychiatric research projects may consequently be poorly fitted to compete for research grants. It is therefore recommended that administrators accept that research is a legitimate and essential item in their budgets, and that a pre-determined amount, in the order of 5% of the total expenditure on psychiatric services, be set aside for research.

We believe that these recommendations should be implemented as soon as possible.

APPENDIX A

MENTAL DEFICIENCY

If one might accept as a valid promise that one of the main reasons that the psychiatric patient has tended to receive care inferior to that of the general hospital patient is due to the longer range-treatment program, recurrence of his illness and (in a substantial number of patients) chronicity of his condition, it follows that the mentally retarded patient, whose mental retardation is a life-time condition, is even more discriminated against.

The reason the mental deficient patient has been linked to the field of psychiatry is somewhat obscure since, he might equally be placed under the direction of the Department of Education, the care of the pediatrician or the neurologist.

What appears historically apparent, is that as long as the psychiatric patient has so many unsatisfied requirements, the mentally retarded patient will receive only minimal attention.

In many areas of Canada and the United States, separate divisions dealing with mental retardation have been set up so that they may devote their undivided attention to this serious problem.

In Canada there exists no specialty in mental deficiency. As a result according to present government classification, it is not possible to employ a physician with experience or background in this field with a salary which might attract experienced physicians. The only available appointment in both institutes for mental retardation in Alberta, is Medical Officer I. If more senior positions were made available they would still be linked to training in psychiatry rather than pediatrics, neurology or mental deficiency.

Proposal:

1. That a Department of Defectology be established and be placed directly under the Department of Youth, or a separate sub-division of the Department of Health.

2. A multi-disciplined group be formed of specialties concerned with the training, education and physical and psychiatric care of the mentally retarded.

3. In view of the fact that mental deficiency is a chronic long-range care program; the establishment of a farm settlement similar to the social organization of the Hutterite Colonies, which could be operated by trained well-adjusted mental defectives and other than the capital costs for original acquisition, could be made self-supporting and probably return the initial investment. This would enable the mentally retarded, once they reach adult life, to live a normal existence away from the institutional 'hospital' setting and permit the training schools to assume the role of training the mentally retarded and discharging them,

once their training was completed. This rather than retaining a stagnant pool for total life responsibility of all mentally retarded rather than only the severe physically as well as the profoundly mentally retarded.

4. Chronic hospitals be set up for the grossly physically handicapped retarded patient, as well as the profoundly mentally retarded patients.

5. The establishment of a specialty of Mental Deficiency with accreditation, since mental deficiency is no longer an isolated rare phenomenon, but affects as many people as most of the major illnesses extant today.

6. That an active research council be created who need concern themselves only with research aspects of mental deficiency rather than actual care of administrative procedures.

These recommendations could be amplified and gone into in greater detail if required.

Dr. L.J. le Vann

APPENDIX B

THE ALBERTA PAEDIATRIC SOCIETY

The Alberta Paediatric Society would like to make recommendations for improvement in the care of the Mentally Retarded.

The subject of Mental Retardation has long been a concern of paediatricians in the Province of Alberta. The Alberta Paediatric Society recently set up a Committee on Mental Retardation to consider recommendations in the brief prepared and submitted by Her Honour Judge Majorie Bowker in 1965. The purpose of our letter is to endorse the recommendations contained in this brief and to urge their implementation.

We in the medical profession are greatly concerned over the inadequate facilities for care of mentally retarded children, many of whom come to our attention during the course of our professional work. Residential facilities, at no time adequate, have failed to expand with our growing population and with the increasing number of children requiring such care. The Alberta School Hospital in Red Deer is an excellent facility for those fortunate enough to gain admission but is by no means adequate for the needs of the Province.

The situation has become increasingly acute, aggravated in large measure by differences in opinion between the Departments of Health and Public Welfare in respect of jurisdiction and responsibility. Since efforts over the past several years have failed to resolve these differences, the Alberta Paediatric Society considers it an obligation to present to the Government the seriousness of the problem as viewed by the profession.

Perhaps the situation can best be illustrated by an examination of existing facilities for the mentally retarded in the Province:-

1. Rosecrest Home - Edmonton - This 60-bed receiving centre operated by the Department of Public Welfare is intended for temporary placement of emergency cases and as a receiving home for babies approved for adoption. It is, however, regularly overcrowded with mentally retarded infants for whom no other placement can be arranged.

2. Welwyn Manor - Wetaskiwin - Retarded children ranging in age from infancy to five years are cared for in this home in the expectation that they will be transferred to the Alberta School Hospital at the age of six years. Although Welwyn Manor has a capacity for 44 children, it frequently houses in excess of this number due to the increasing demands for placement of young children. At present there are 26 children over five years of age being cared for, despite the fact that this home is not designed or equipped for older children, who are in need of the type of facility provided at the Alberta School Hospital.

3. Providence Creche - Calgary - The Creche is also designed for infants, but is frequently required to accommodate older children, and is similarly overcrowded due to difficulties in arranging transfers to Red Deer.

4. Baker Sanitarium - Calgary - The conversion of part of the Baker Tuberculosis Sanitarium as an infant infirmary can be best described as a stop gap. At present it is accepting only mentally retarded infants who have a medical or surgical problem as well. The Child Guidance Clinic in Edmonton does not recommend for admission to the Baker Sanitarium in Calgary infants who, although grossly retarded, have no pressing surgical or medical problem. Dr. Lester Pearson, Director of Medical Services in the Department of Health, has been very helpful in getting some of these children into anciliary hospitals throughout the Province. Though much appreciated, this is nevertheless a misuse of facilities, and at best only a short-term remedy.

5. Foster Homes - In the past, foster homes have been available for infants and very young retarded children. Because many women who formerly took foster children are now finding more lucrative employment outside the home, the supply of foster homes even for normal children is rapidly declining. This points up the need for more nursing homes and institutions for the younger retarded children.

6. The Alberta School Hospital - Red Deer - The situation in this institution is well known. For years it has been filled to capacity with over 800 retarded children age six years to adulthood, with a waiting list estimated at 500. Deerholm at Red Deer has approximately 1,000 adult retardates. The need for additional school hospitals in Alberta has long been evident, yet to our knowledge no plans for additional facilities have been formulated.

A recent survey carried out by the Child Welfare Branch of the Department of Public Welfare shows 195 mentally retarded children certified by the Child Guidance Clinic for placement in the Alberta School Hospital but still awaiting admission. It is estimated that in addition there are some 300 children with varying degrees of retardation who still await examination at the Child Guidance Clinic. These figures cover government wards only. No mention is made of the undetermined number of private cases for which institutional care should be considered.

Understandably, there are instances in which neither the Department of Health nor the Department of Public Welfare is willing to accept responsibility, the one claiming it to be a health problem, the other a welfare problem. Admittedly there is an area of doubt as to where welfare jurisdiction ends and health jurisdiction begins. It would be our suggestion that where for emotional or other reasons parents neglect or refuse to care for a retarded child, the child should become a ward of the Department of Public Welfare, to be cared for in facilities provided by the Department of Health, since in our opinion this is basically a health problem. It would seem that the Department of Public Welfare has enough responsibility to provide homes and institutions for other categories of "neglected children" suffering from physical or mental abnormalities.

We in the medical profession see an urgent need for more facilities for very young retarded children (under the age of six) and also for additional school hospitals for those over six. We also feel the time has come, as recommended in Judge Bowker's Brief, for the Government to appoint a "Provincial Council on Mental Retardation", composed of knowledgeable citizens to act in an advisory capacity to the Government in coordinating the present fragmented services now being offered by voluntary organizations, government departments, educational institutions, and parents' groups. Such a Council would provide long-range and continuing guidance to government planners at a time when austerity demands the best use of public funds and when current policy stresses the development of human resources.

Dr. P.J. Kimmitt,
President

APPENDIX C

Brief on Mental Retardation - M.M. Bowker

Summary of Findings and Recommendations

Findings

1. There is a lack of public awareness in Alberta of the magnitude of the problem of mental retardation and its seriousness as one of our major health problems.

2. 3% of Canada's population are mentally retarded.

3. The present policy in Alberta is to encourage parents to care for their retarded child at home. This policy pre-supposes availability of clinical and counselling services which do not exist in the Province to a degree commensurate with the need.

4. Facilities for placement outside the home are extremely limited.

5. Special services for the retarded are not available outside the larger cities. Nor are there hostels to accommodate and counsel employable retardates in their adjustment to community life.

6. A close correlation is known to exist between mental retardation and a lack of pre-natal care. The prevalence of mild retardation is greatest in families at the low socio-economic level where cultural stimulation is lacking.

7. There is a fragmentation of services for the retarded as shown by the following division of responsibility.

Service	Government Department or Agency
Health	Department of Health
Education	Department of Education, Local School Boards, Parent Groups
Guidance Clinics) Training Schools)	Department of Health
Rehabilitation	Voluntary Agencies
Job Placement	Employment office and voluntary agencies
Recreation and Religion	Nil
Public Education	Parent Groups

8. To date, Alberta has contributed very little to research.

9. Notable advances have taken place in the past decade elsewhere indicating the need for an enlightened and vigorous programme here.

10. 'Prevention' in the field of mental retardation includes: detection of genetic causes, early diagnosis, treatment, training and special education of the retardate to prevent deterioration and to realize his full potential and expansion of research.

Recommendations

1. That the problem of mental retardation become a major component of preventive health services in Alberta.

2. That co-ordination and integration of the services of various government departments, volunatary agencies and parents' groups be provided through a "Provincial Council on Mental Retardation."

3. That clinical and counselling services be available on a regional basis throughout the province to assist parents in planning for the care, treatment and training of the retarded child.

4. That public health nurses be alert to the detection of retardation in rural areas and capable of assisting parents.

5. That consideration be given to the needs of parents and other members of the family in deciding on future care of the retarded child, and in cases where parents, for economical or other reasons, desire placement of the child outside the home, facilities for such should be available.

6. That immediate plans be made for the erection of another School Hospital or several smaller such centres, as well as nurseries for severely retarded infants and younger children. Provision should also be made for short-term residential care of a retarded child where parents require a holiday. All such facilities should be provided at nominal cost.

7. That foster mothers be given continuing counselling and direction and be paid a per diem rate equal to the responsibility entailed.

8. That an assessment be made as to the need for additional day schools, especially in smaller centres.

9. That emphasis be placed on job placement of the mildly retarded and that hostels be provided for short-term accommodation during the transition to community living.

10. That research be encouraged through public and private funds.

Recommendations

1. That the Alberta Paediatric Society support the recommendations contained in Judge Marjorie Bowker's Brief on Mental Retardation.

R.C.B. Corbet, M.D.
Chairman
Brief Committee
Alberta Paediatric Society

Dear Sir:

I have been instructed by my executive to inform your committee of the opinion of our Medical Staff, who consider the best interests of the mentally ill of our region, would be served by observation of the following principles.

(a) Throughout the world, the modern trend is to treat as many as possible of the mentally ill in a General Hospital. With the armentarium of psychotropic drugs now available such patients may be treated in a general ward with success whereas in a former decade they would have necessarily been transferred to a mental institution. Thus in this modern age it is possible for mental patients to be treated similarly to general medical patients and so prevent their segregation which is strongly deprecated by psychiatrists throughout the western world. By treating such patients in their own community there is a complete avoidance of any stigma which is still attached to mental illness and also their relatives are able to visit as frequently as they do when the patients are suffering from non-mental illnesses.

(b) The building of another mental institution is only continuing the psychiatric thinking of the 19th century and it is hard to believe that such a proposition should even be considered in this day and age. It is probable that such an institution suits a bureaucratic type of mind in that the costing of such an institution may possibly be less than the costing of using wards in a general active hospital. We feel that this is a retrograde thinking which should not play any part in the final decision, as surely the care of the patient must remain uppermost.

(c) Even without any extra facilities a large number of mentally ill patients are being treated daily in general hospital wards by doctors with consultant assistance and it would only need a little extra expense in providing some occupational therapy and psychiatrical social workers to make the facility more complete.

(d) In view of the fact that many long term patients of the Ponoka Mental Hospital who require domicilary treatment only, are being transferred successfully to the regional nursing homes and simultaneously more and more psychiatric cases are being treated in general wards, it appears to be an ill-judged decision to consider building another large institution at the time of national economic stringency. The present establishment at Ponoka would appear to be sufficient for our present and future requirements.

In summary, the opinion of our Medical Staff is that the building of a new mental institution which automatically tends to continue the dichotomy of patients according to their illness, is a retrograde step. We strongly urge the commission to recommend that improved facilities, such as an extra ward, accommodation for occupational therapy and psychiatric social workers, which in financial comparison would be of a minor nature, should be provided at the regional hospitals for the treatment of mental cases. Then the present institution in Ponoka will be able to manage those cases which, due to deterioration of personality or extreme severity of illness, require such institutional treatment.

Dr. A.C.S. Hobson,
President Medical Staff,
Medicine Hat General
Hospital.

OPPORTUNITY ENTERPRISES

This letter is to serve as a brief from our organization for the consideration of your group.

In order that you may understand the reason for our submission it seems desirable that we give you some history of our organization and outline its purpose. For many years Dr. Phillips and several social workers have endeavoured to find employment for mental patients on a part time or even full time basis and people of the community co-operated fairly well. However, there is a limited amount of work that can be obtained on this basis and little real progress was made in finding employment for patients. At a well attended meeting at the hospital about two years ago, Dr. Phillips again stressed the need for employment for patients as a re-habilitive measure and it was decided to form a committee composed of hospital employees and interested people from the community. A meeting was called and from this Opportunity Enterprises was formed, its purpose being to assist mental patients with their re-habilitation firstly through establishment of a sheltered workshop and secondly by assisting them to find places to live including the establishment of a half-way house.

The group is composed of several local business and professional men and an approximately equal number of employees of the local Alberta Hospital. Having no experience in planning and operating a workshop, we at first tended to go to government departments for help. Mr. Erick Schmidt attended one of our meetings outlining help available through various government programmes but it was apparent that obtaining help through these agencies would require submission of more sophisticated plans than our group was capable of making. We were also in touch with the Department of Trade and Industry and a representative of that department met with us. While many different ventures and products were mentioned, no practical suggestions were made as to how to proceed to convert the ideas into actual work contracts. We wrote to several places where we heard similar workshops were operating but in every case either received no reply or so little information that it was of little use to us. We finally decided that if we were ever going to get the workshop started we would have to work it out ourselves.

Our first step was to incorporate under the Society's Act and after some months obtained registration. We had no money available for equipment, initial expenses, or working capital and although we could raise some money among our own members it would be inadequate. We approached a local organization known as the Ponoka Industrial Development Corporation Limited and we were very grateful to have their assurances of backing up to $3,000. Our next problem was premises in which to house the workshop. The Town of Ponoka purchased the armouries building a few years ago and council agreed to lease it to us at a nominal rental for one year, the lease to be re-negotiated at that time. In the meantime we had written to Doctor Byers and to the Minister of Health for permission to employ patients in the workshop. You will realize some difficulty could be encountered in this area as the patients are under the care and control of the medical superintendent and he is responsible for them. We suggested to the Minister of Health that the workshop be considered as an extension of the occupational therapy ward in the hospital and that the patients at all times be accompanied by a psychiatric nurse. Both the Minister of Health and Doctor Byers concurred with our suggestion and hospital authorities generally have been very co-operative with us.

At this stage we were all ready to start work except for the biggest hurdle of all -- that of obtaining work contracts that were within our capacity and would be sufficiently remunerative to pay the small overhead involved and some wages to the patients. Mr. Crowhurst, a social worker at the hospital, spent a great amount of time and trouble endeavouring to find suitable contracts and had it not been for his efforts we might not have ever succeeded in starting our workshop. We soon found that most of the tedious handwork was being done by machines and that there was not much work available for unskilled people. Just when we were so discouraged that we were almost ready to give up, the Snack Shop, a lunch counter operated by the patients in the hospital, offered us a gift of $4,000 to assist in getting the project underway. The patients had been following our efforts to establish the workshop and wanted to help in this way. With this vote of confidence from the patients we redoubled our efforts and soon met with some success when Mr. Crowhurst obtained a contract to make rubber mats for an Edmonton firm. We now have six or seven men steadily employed at the workshop and have reasonably good prospects of obtaining more contracts soon. The workshop is being run by Jack Hetherington, a psychiatric nurse, and he reports he has never seen such a favourable change in outlook as has occurred among the men employed.

We have also been attempting to find homes for patients considered ready for discharge and to establish a half-way house. We did some advertising for homes and a group of us appeared on Red Deer T.V. requesting the co-operation of the public. We met with some success but the number of people willing to accept patients into their homes is limited. Reverend Harry Shell is in charge of this committee and he is now endeavouring to establish a half-way house here. It seems probable that it will be in operation by this mid-summer and will be capable of housing seven male patients. The purpose of the half-way house is to allow patients to participate in and become involved in the life of the community to the extent that they are able.

The purpose of our brief is to indicate the difficulties any volunteer group will encounter in starting an enterprise of this kind and to offer some suggestions as to assistance that might be given by government authorities. We believe this type of assistance to patients is important and that it is better rendered by volunteer groups which should be able to establish a more free atmosphere than is usually found in most institutions. We recommend that government assistance be considered in the following categories:

1. Some general guide lines as to responsibilities to the volunteer group and of the Department of Health.

2. Appointment of a provincial advisory board to assist in the establishment of workshops and in finding work to be done. It would probably be best if such a board were a voluntary one composed of people from industry, from labour groups and possible a representative from Canada Manpower and a social worker.

3. Some initial financial assistance to obtain equipment and meet expenses until the workshop is able to pay its own way.

4. Some financial assistance in establishing half-way houses for patients who may be able to live out but still require treatment from the hospital. The assistance would probably take the form of paying the rent for the first month or two and possibly providing some furniture.

We are enclosing a copy of a Statute of the State of Washington creating the Institutional Industries Commission. While the Act was designed for penal institutions and many of its regulations would not apply to mental institutions, the general intent is of interest and might form the basis for similar legislation in Alberta possibly for both penal and mental institutions. (Not recorded here. WRNB)

There is another matter which is not one of the main purposes of this brief but which may become a problem in the foreseeable future. If our workshop operates as successfully as we hope, there should be a number of patients leaving for outside employment. Many of these are capable workers and will have little trouble re-establishing themselves economically. However, there will be others who operate at a lower physical and mental level who will have difficulty finding employment and, in fact, may never be sufficiently productive to hold a steady job. A check of unemployment statistics would probably show that there are a number of other people who have never been in a mental hospital who have the same problem and because of their low productive ability are almost permanently denied the right to work. Social welfare may solve their economic difficulties but psychologically this rejection must be devastating to the individual. We realize organized labour may be opposed to any weakening of protective legislation in connection with hours of work and minimum wages. However, when a person is denied the right to work at all because he is not able to become an efficient worker, it would seem that some provision should be made for special categories of work which he might do at less than standard wages. To operate special workshops or factories to employ such people permanently might be a partial answer but it would seem better to let them work with the rest of the people instead of being segregated into special workshops.

K.J. Wolstenholme
President
Opportunity Enterprises
P.O. Box 490
Ponoka, Alberta

CHAPTER 5

ORGANIZATION AND ADMINISTRATION[1]

Scope of Examination

As recorded in Chapter 1, the Alberta Mental Health Study was expected to produce recommendations for the development of an improved, comprehensive and integrated program for the diagnosis, treatment, care and rehabilitation of the mentally ill and for the prevention of mental illness in the Province. The Study Group on Organization and Administration could not know in advance the precise nature of any program which might be introduced by the Government following receipt of the report on the Study. Therefore, it could not be expected to specify means whereby mental health services in Alberta could be properly planned, organized and controlled. In addition, the Study Group could not reasonably be asked to propose the most efficient organizational structure by means of which the objectives of a new (and undefined) program might be achieved.

It was possible, however, to have the Study Group examine and evaluate the current organization and administration of the Division of Mental Health and to estimate its capacity for change and probable operational efficiency in relation to an anticipated program. Second, the Study Group was able to consider the organizational implications of the major principles identified by the Alberta Mental Health Study and to propose an organizational structure which could be considered by the Government if the recommendations of the Study based on those principles were implemented. The Study Group focussed its efforts on those two tasks. Readers of this part of the report must recognize that it cannot be complete or definitive. It will deal with current deficiencies, some important principles taken from professional management, which should be observed in any reorganization and an organizational outline, which is consistent with the principles and major recommendations of the Alberta Mental Health Study. Decisions of the Government on the recommendations of the Study, however, will have to be followed by further examination to determine in detail the organizational and administrative requirements of any new form of mental health service. It will be clear from the remainder of this Chapter that professional management experience will be required in that phase of the operation.

Design of Examination

The work of the Study Group took the form of interviews with persons intimately involved with the current mental health program in the Province, resource persons with special knowledge relevant to the Study and outside consultants, whose names are listed in the INTRODUCTION.

The Study Group received several submissions from interested individuals. Documents which were the subject of special scrutiny, included:

Board of Visitors Report, 1967

Report of a Consultation to the Minister of Public Health on the Psychiatric Services of Saskatchewan, 1967.

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[1] This Chapter is based on reports from the Study Group on the subject named in the title. WRNB

The Alberta Mental Health Act

Annual Reports of the Division of Mental Health

Organizational Charts of the Department of Health

More for the Mind

The Study Group on Organization and Administration engaged in a survey of informed opinion. Its work is not the result of a rigorous research project and must not be regarded as such.

Administrative Structure of the Existing Mental Health Program

The Study Group began its examination of the current administrative structure in the context of previously determined problem areas. Two conclusions resulted from that initial examination. First, the Study Group discovered that professional management, its philosophy, purpose, attitude, approach and activities, is not apparent in the administrative structure or operations of the existing mental health program. Second, because of accumulated deficiencies, attributable to lack of professional management, the current administrative structure is untenable as a foundation for planning, organizing and controlling mental health services in the Province. It is also unsuitable as a basis for developing the most efficient organizational structure by means of which the objectives of a new, comprehensive and integrated mental health program could be achieved.

At the outset, the Study Group had thought it reasonable to assume that the objectives of the current mental health program and standards of administrative performance within the program had been defined and communicated. Moreover, it was assumed that executive leadership would be present in the current program to the extent necessary to ensure efficient operations. The Study Group reported that support for those basic assumptions was not found in their early investigations. Instead of being able to proceed to an appraisal of operational results, therefore, the Study Group had to put aside the assumptions and try to discover why they could not be made.

Objectives and Deficiencies of the Existing Program

Although the Government of Alberta defines the objectives of the Division of Mental Health as being "concerned with the prevention and treatment of mental disorders and with mental health generally",[2] the Study Group concluded that the Division is almost exclusively concerned with the treatment of mental illness.

In keeping with its essential concern, the Division has established courses of action, policy and procedures whereby individuals are diagnosed, admitted to an institutional structure, treated within it and released from it. Because of its emphasis on the treatment of mental illness, the Division has very little time or resources to devote to rehabilitation and other mental health problems, like the prevention of mental illness within the

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[2] Department of Health, Province of Alberta, *Mental Health Services*, Queen's Printer, Edmonton, p. 1.

Province. The Division is not organized in a manner which would enable it to achieve the objectives of a mental health program directed toward the prevention and treatment of mental illness and concerned with the problems of mental health generally, as defined by the Government.

The absence of well defined objectives, in actual practice, was considered by the Study Group to be a critical deficiency. They pointed out that confusion tends to develop when organizational objectives are not clearly specified, communicated and understood. They stated in this regard, "Because of the lack of clearly defined objectives within the mental health program, the Study Group discovered a lack of coordination, a lack of willing cooperation, a lack of morale, the expenditure of effort to attain goals which were in conflict with each other and a lack of control."

The Study Group noted the following additional deficiencies:

1. Senior personnel are almost invariably psychiatrists, who are not trained in professional management although they are in managerial positions, at least in the majority of cases.

2. Administrative standards of performance, executive leadership, policies, physicial facilities, personnel and the whole organizational structure, set of systems and procedures are all oriented toward institutional treatment.

3. Excessive emphasis on institutional treatment by the Division of Mental Health has led to relative neglect of other kinds of treatment, of rehabilitation and of prevention in the total mental health system.

4. Prevention of mental illness requires a substantial investment of money and resources in both research and education but both activities are seriously neglected in the existing mental health program.

Evidence of confusion in objectives and in related organization and programs, is shown in the Department approach to alcoholism. A division, which is separate from the Division of Mental Health, is responsible for plans and programs relating to alcoholism, but the Alberta Hospital, Edmonton, which is controlled by the Division of Mental Health, is required to receive and treat acute alcoholics, in addition to those who are classed as mentally ill. Alcoholism Clinics function as entities separate from the Guidance Clinics, which are controlled by the Division of Mental Health. Alcoholism appears to be viewed by the Department as a health problem generally, a mental health problem frequently, but only in the latter case when no one knows what to do with it.

Standards of Administrative Performance

Administrative performance relates to the functions of planning, organizing, directing, controlling and coordinating. Thus, it is concerned with such activities as the specification of objectives and plans and the measurement of the degree of attainment of objectives and includes data collection, the preparation of budgets and personnel administration. It also refers to the way the Division relates to patients, relatives of patients, health professionals, employees within the system and the general public.

In connection with the relationships named above, the Study Group observed a rigid application of the Mental Health Act by the Division, with insufficient regard for the apparent intent of the Act or the public interest. Standards of administrative performance appeared to the Study Group to be dictated narrowly by the Act, instead of being based on the Act and subject to continuous review and modification.

In the case of administrative functions, a lack of performance criteria was noted. Personnel in lower management echelons are inadequately informed about their authority and responsibility in planning, organizing or controlling, if indeed they are intended to have any role in that context. Although units comprising the Division develop their budgets, they are reviewed and integrated into a master budget by head office without sufficient regard for the plans they represent. Once a budget is approved centrally, it becomes a plan instead of a quantitative expression of a plan. Accordingly, the objective becomes that of spending the amount budgeted as opposed to using the monies available to achieve a specified objective through the execution of a program. Consequently, by violating the principle "Plan the work and work the plan", the Division moves from crisis to crisis in its administration and organization structure. As with the application of the Act, restrictive and unimaginative control of administrative conduct was seen to be the prominent characteristic of management.

Some statistical information is collected within the Division of Mental Health but it is in a primitive state, both in terms of design and content. The data deal largely with such factors as numbers of admissions, diagnoses, length of stay and readmission. The information appears to be used primarily to meet the requirements of the Dominion Bureau of Statistics and it does permit a crude comparison of institutional operations from year to year. The data are quite insufficient, however, to facilitate an evaluation of the effectiveness of mental health programs or to develop long range plans in any area of operations or development. This deficiency, in the judgment of the Study Group, also reflects a lack of professional management.

Executive Leadership

Responsibility is fixed by headquarters of the Division of Mental Health in lower echelons in the system, but authority is almost totally centralized. The rights of decision and command, which are so essential to executive leadership, are withheld from senior subordinates but those personnel are still held accountable for their acts. The results of this kind of leadership were seen by the Study Group to be: low morale, loss of professional employees, virtually no innovation within the system and the discouragement of independent, imaginative thinking in the lower management echelons.

Related Problem Areas

The absence of clearly defined objectives has prevented the development of sound policies within the system. Resource persons interviewed by members of the Study Group emphasized that policies, which had evolved, tend to be implied, rather than stated expressly. These policies are also reported to be applied inconsistently. Other major problems were identified and reported by the Study Group:

1. Lack of proper job descriptions, which are basic to personnel decisions.

2. Inadequate attention to recruiting, selection and staff development.

3. Lack of sensitive and well-informed management, particularly as applied to professional staff, resulting in diminished capacity for personal growth and satisfaction and unnecessary staff losses.

4. Poor communication between lower management echelons and headquarters, and the reverse, with adverse effects on morale and a failure to make the best use of talents within the system.

5. Lack of long-range planning, with the result that the need for physical facilities, staff and programs is usually at hand before a plan is ready to meet the need.

6. Rigid, centralized control and coordination of facilities and staff and little, if any, consultation outside headquarters regarding the development of long-range plans.

7. No clarification or distinction between procedures, which apparently are the responsibility of lower echelons, and policy, which is reserved for headquarters' decisions.

8. Restricted use of accounting and reporting functions, (labelled by the Division as "business management"), isolated from other operations, instead of being an integral part of the whole system.

9. Lack of sound functional relationships with other agencies, divisions, and departments which could contribute to the development of a more comprehensive and effective program for mental health.

Summary and Conclusions

A Study Group, comprised of responsible and appropriately qualified personnel, has conducted an examination of the present organization and administration of the mental health service of the Province to determine whether that organization would be capable of supporting a new, comprehensive and integrated program. The Study Groups' findings, as summarized above, indicate that the present organization and administrative structure are not adequate to support even the limited mental health operations undertaken by the Division of Mental Health today. A new organizational structure and administrative system must be provided if an improved mental health program is to be achieved.

Suggested Structure

A new structure and system cannot be specified in any definite way in advance of the Government's decisions regarding the recommendations of the Alberta Mental Health Study. It is possible, however, to describe some of the necessary ingredients.

1. Professional management is required to plan and operate mental health services. If it is decided that psychiatrists must be assigned to those functions, then they should be trained in management.

2. Institutional treatment, the present orientation of the Division of Mental Health, is an unacceptably narrow view of mental health problems and needs. The wider orientation, which is required, would necessitate involvement of many services and resources, which lie outside the responsibility of the Division. That involvement, in turn, would demand integration, coordination and active liaison at all levels, local, regional and provincial, if the whole operation is to be a success.

3. The unnatural separation of mental health from other kinds of "health", and the inexplicable division of mental health and alcoholism, prevents the maximum utilization of facilities and personnel at all levels of operations. Economy, efficiency of operations and adequacy of treatment and care demand that these organizational absurdities be abandoned promptly.

   The separation of mental health within the organization of health services is contrary to all informed opinion encountered during the Study, outside of the Department of Health. Many briefs condemned the practice; none spoke in favour. Two national studies of importance have recommended the union of health services and organization:

   > More for the Mind, 1963--"Mental illness should be dealt with in the same organizational, administrative and professional framework as physical illness." (3)
   >
   > Royal Commission on Health Services, 1964--"That henceforth all the discriminations in the distinction between physical and mental illness in the organization and provision of services for their treatment and the attitudes upon which these discriminations are based be disavowed for all time as unworthy and unscientific." (4)
   >
   > In addition, the Public Expenditure and Revenue Study Committee of the Alberta Legislative Assembly came to a similar conclusion in 1965.--"It will be noted, too, that

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[3] Tyhurst, J.S. et al. More for the Mind. A study of psychiatric services in Canada. Canadian Mental Health Association, Toronto. 1963, p.38.

[4] Hall, E. Report of the Royal Commission on Health Services, Ottawa. Queen's Printer, 1964, Vol. 1. 31.

> the mental hospitals and the tuberculosis sanataria are administered by divisional directors reporting to the Deputy Minister while the other hospitals are administered by the Hospitals Division. The Committee questions the wisdom of this separation and recommends that all hospitals be placed under the jurisdiction of the Hospitals Division. Should this be done consideration should also be given to establishing a board for each of these institutions."(5)

4. Communication between elements of the mental health service must be improved dramatically over the present unsatisfactory condition. Provision for improvements can be made in part through an appropriate organizational structure with well defined channels of communication and relative responsibilities. A high quality of leadership is also required, however, to take full advantage of the talents dispersed throughout the system.

5. Long-range planning, coordination, standards and financial control are proper responsibilities for the Department of Health. The headquarters elements of the Department, however, should not become directly involved in local administration or operations.

6. Delegation of authority for administration and operations to local levels is indicated if local resources are to be mobilized into an efficient program.

7. An effective information system is required to support the planning and controlling functions of the headquarters part of the Department of Health.

8. Provision for continuous attention to the personnel staffing the organization must be made. A senior officer at headquarters should have that responsibility.

The organizational structure shown in the following chart would assist in overcoming a number of the deficiencies which have been reported. It is included in this report as a means of stimulating thought and to indicate an approach which would be consistent with the findings of the Alberta Mental Health Study. It is based on the assumption that some form of health services commission will be introduced. That possibility has considerable appeal because it offers a means of effecting necessary improvements, including a major relocation of responsibility, authority and personnel.

(See organizational chart on following page.)

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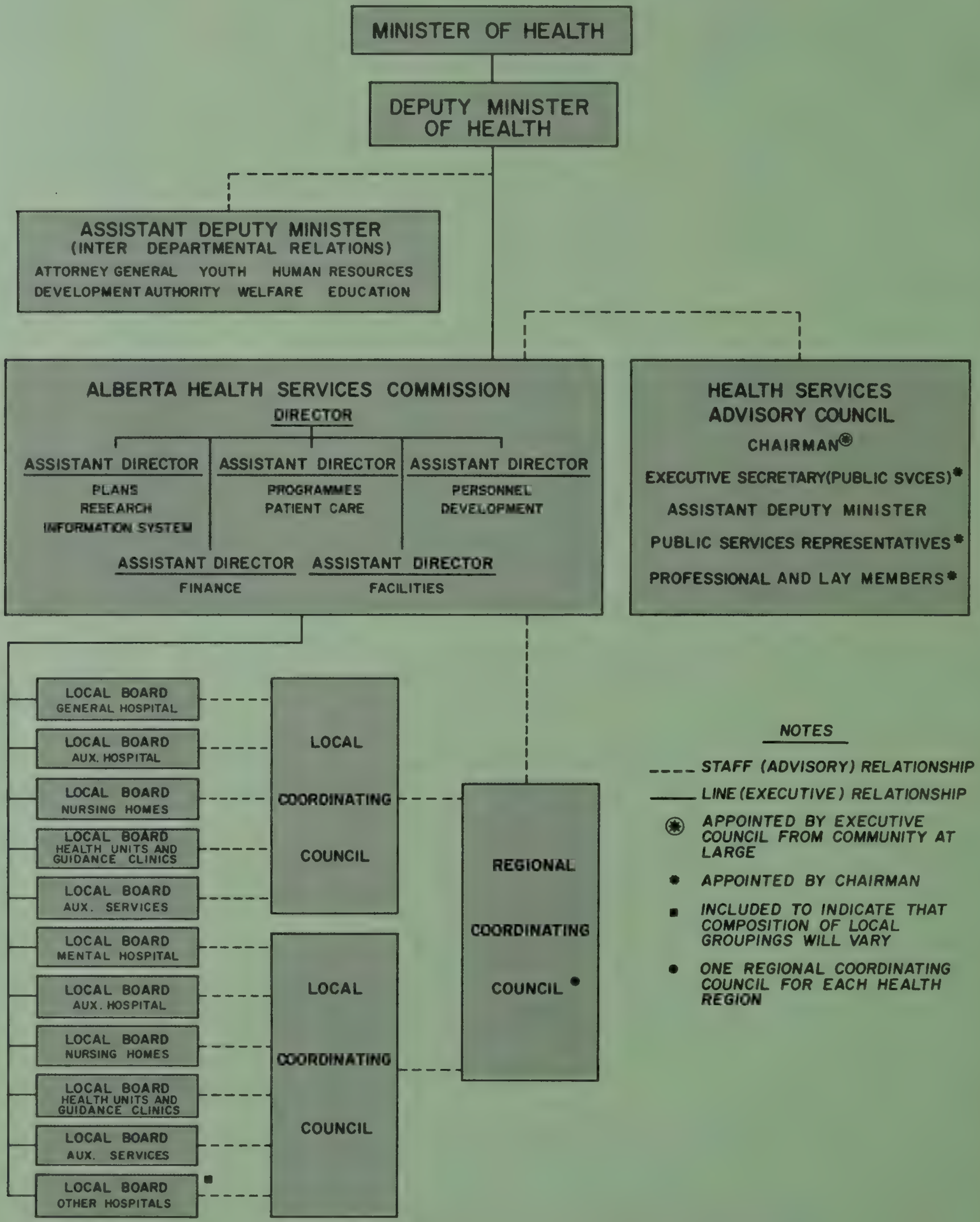
[5] Report of the Public Expenditure and Revenue Study Committee of the Alberta Legislative Assembly, 1965, p. 8.

PROPOSED ORGANIZATION OF HEALTH SERVICES


MINISTER OF HEALTH
DEPUTY MINISTER OF HEALTH
ASSISTANT DEPUTY MINISTER (INTER DEPARTMENTAL RELATIONS)
ATTORNEY GENERAL
YOUTH
HUMAN RESOURCES
DEVELOPMENT AUTHORITY
WELFARE
EDUCATION
ALBERTA HEALTH SERVICES COMMISSION
DIRECTOR
ASSISTANT DIRECTOR
PLANS
RESEARCH
INFORMATION SYSTEM
ASSISTANT DIRECTOR
PROGRAMMES
PATIENT CARE
ASSISTANT DIRECTOR
PERSONNEL
DEVELOPMENT
ASSISTANT DIRECTOR
FINANCE
ASSISTANT DIRECTOR
FACILITIES
HEALTH SERVICES ADVISORY COUNCIL
CHAIRMAN⊛
EXECUTIVE SECRETARY(PUBLIC SVCES)*
ASSISTANT DEPUTY MINISTER
PUBLIC SERVICES REPRESENTATIVES*
PROFESSIONAL AND LAY MEMBERS*
LOCAL BOARD GENERAL HOSPITAL
LOCAL BOARD AUX. HOSPITAL
LOCAL BOARD NURSING HOMES
LOCAL BOARD HEALTH UNITS AND GUIDANCE CLINICS
LOCAL BOARD AUX. SERVICES
LOCAL COORDINATING COUNCIL
LOCAL BOARD MENTAL HOSPITAL
LOCAL BOARD AUX. HOSPITAL
LOCAL BOARD NURSING HOMES
LOCAL BOARD HEALTH UNITS AND GUIDANCE CLINICS
LOCAL BOARD AUX. SERVICES
LOCAL BOARD OTHER HOSPITALS ■
LOCAL COORDINATING COUNCIL
REGIONAL COORDINATING COUNCIL ●
NOTES
---- STAFF (ADVISORY) RELATIONSHIP
—— LINE (EXECUTIVE) RELATIONSHIP
⊛ APPOINTED BY EXECUTIVE COUNCIL FROM COMMUNITY AT LARGE
* APPOINTED BY CHAIRMAN
■ INCLUDED TO INDICATE THAT COMPOSITION OF LOCAL GROUPINGS WILL VARY
● ONE REGIONAL COORDINATING COUNCIL FOR EACH HEALTH REGION

As indicated in the diagram, line authority extends from the Minister of Health, to the Deputy Minister of Health, to the Alberta Health Services Commission, to Local Unit Boards. In support of the line authority, it is proposed that there should be an Assistant Deputy Minister, who would be responsible for inter-departmental relations (Health, Welfare, Attorney General, Education, Youth and Human Resources Development Authority), a Health Services Advisory Council (comprising the Assistant Deputy Minister, outside professional and lay personnel and certain members of the Public Service), the Regional Coordinating Councils, all serving in a staff (advisory) rather than a line (executive) context. The Chairman of the Health Services Advisory Council would be appointed by the Executive Council. The Chairman would then have authority to make all other appointments to the Council, including that of the Executive Secretary, who should be a permanent and senior member of the Public Service.

The chairmen and members of the boards of local units would have a high degree of autonomy. However, the Director of the Alberta Health Services Commission would be responsible for ensuring that the chairmen and members of the local boards performed in a proper fashion. In addition, their budgets would be approved by the Director of the Commission and would be subject to the ultimate authority of the Minister of Health. Once a budget had been approved, the local boards would have full responsibility for operating within the budget. Of course, proposed budgets from local boards would have to be supported by detailed statements of the operational objectives to be achieved during a budget year and of the plans by which they would be achieved.

The Assistant Director of Planning, Research and Information Systems would be responsible for generating, maintaining and analyzing the data required for the efficient operation of health services, for the development of effective reporting systems within the services, for continuous within-service operational research, for the development of long-range plans and for the stimulation of basic and applied research in support of health services generally.

The Assistant Director of Finance would be the principal financial officer within the Ministry of Health. He would be responsible for the coordination of all budgets, and the appraisal of financial matters which require ultimate approval by the Minister. In addition, he would be responsible for the development of well-defined systems and procedures pertinent to financial control, and for the regular inspection of financial operations of all types of local units.

The Assistant Director of Facilities would be responsible for new buildings, additions to buildings, maintenance of building standards, purchasing, cost analysis of operations and other factors basic to the efficient use of the facilities.

The Assistant Director of Programs and Patient Care would be responsible for the supervision of programs and the maintenance of defined standards of patient care in all types of local units.

Salaries of all paid employees would be subject to approval by the Commission, which would also prescribe personnel standards and policies. The Assistant Director of Personnel Development would assist local unit boards in establishing comparable job descriptions and in recruitment, according to approved standards. He would also assist in the development and implementation of staff training programs.

The Coordinating Councils would be concerned with the integration of activities and services at the local and regional levels in order to obtain maximum benefit from the operation of the delivery system.

Coordination at Government Level

Coordination within the Government of more than the divisions of the Department of Health is essential. The Departments of Welfare, Youth, Education and the Attorney General are becoming involved to an increasing extent in functions which relate to those of Health. The preventive and rehabilitative efforts of the Departments of Health and Welfare, as an example, have a natural relationship but they require coordination, which is lacking now at every level. Welfare is moving into the areas of diagnosis and treatment, admittedly from their point of view, and the dangers must be apparent. Overlapping services with resultant waste of money and effort, competition for scarce professional staff and less than optimum efficiency are some of the pitfalls which should be avoided.

The Human Resources Development Authority, as a kind of superministry, may be sufficient to coordinate and establish priorities for the related departments. The Assistant Deputy Minister in this proposal also would be concerned constantly with liaison and coordination but an agency, which is senior to the present departments, well informed about their competing demands, and energetically engaged in reconciling them, is definitely required.

RECOMMENDATIONS

1. It is recommended that a new organizational and administrative structure be developed as a first step in the creation of a new program of mental health services for Alberta.

2. The principles, guidelines and organizational structure described in this Chapter should be given full consideration in that development.

3. Action should be taken to coordinate the work of health-related departments and establish priorities for them in a more effective way than is evident now.

4. It is further recommended that professional management consultants be employed in the implementation of the first two recommendations, above.

CHAPTER 6

MANPOWER FOR MENTAL HEALTH, EDUCATION AND TRAINING[1]

Committee

Chairman:	Dr. Keith A. Yonge, M.D., C.M., D.P.M., CRCP (C)	Department of Psychiatry University of Alberta
Members:	Dr. G.H. Ball, M.B., Ch.B., D.P.H. (Public Health)	Medical Officer of Health City of Edmonton Local Board of Health
	Dr. E.R. Haynes, M.B., Ch.B., B.A.O. (Family Physician)	Assistant Professor of Community Medicine University of Alberta
	Professor A.J.B. Hough, M.A.	Director Student Counselling Services University of Alberta
	Mr. G. McLellan, M.S.W. (Social Work)	President Alberta Division of C.M.H.A.
	Miss S. Ryan, B.Sc.(Nursing)	Nursing Education University of Alberta Hospital
	Dr. H.W. Zingle, M.Ed., Ph.D. (Educational Psychology)	Director of Counsellor Education Program University of Alberta
	Dr. P.C. Sartoris, B.A., M.A., Ph.D. (Part time)	University Counselling Service and Educational Psychology University of Alberta

INTRODUCTION

Organization of the Study

With the variety of professional personnel involved in mental health care it was thought best to consider the matter of manpower, education and training for each category separately - psychiatrists, family physicians, psychologists, social workers, nurses, ancillary nursing personnel and others.

For each category consideration was given to:

1. Present manpower situation
2. Standards that have been set for manpower
3. Current situation with respect to education and training
4. Standards that have been set for education and training
5. Estimates of the present and future needs for manpower
6. Proposals for educational and training programs
7. Proposals for recruitment

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[1] This Chapter is the work of the Study Group on Manpower, Education and Training. The conclusions and recommendations are supported by the Alberta Mental Health Study. The footnotes are mine. WRNB

PSYCHIATRIST

Manpower

The number of psychiatrists in the Province of Alberta at the present time is 51. The ratio of psychiatrist to population per 1,000 is 1:30. The present ratio in Canada at large is 1:22. The ratio recommended by the Royal College is 1:15, (Kerr, 1967). Thus, Alberta falls far below the present national ratio and is one-half of the recommended ratio.

However, a simple statistic of this kind is of limited significance because it does not take into account certain important factors such as demographic distribution and variations in functions of psychiatrists.

Of the 51 psychiatrists in Alberta 45 are concentrated in the two major cities of Calgary and Edmonton. One is located at Lethbridge (in private practice) and one at Red Deer (in public service). The remainder are at the Alberta Mental Hospital, Ponoka.

The great majority of psychiatrists in Alberta function in the mode of private practice as personal physicians to their patients, as do most other physicians and specialists. Thus, most of the psychiatrists assume the role of therapist-practitioners individually to patients rather than as consultants to the family physicians or other professionals who initially refer the patients.

In order to begin to meet the demand for this form of psychiatric care the number of psychiatrists in practice would need as a first step to be doubled or tripled. This order of manpower shortage is common throughout North America. It was concluded by the Joint Commission on Mental Health in 1961 that "The United States would quickly absorb the services in the next ten years of two or three times as many psychiatrists as it now has."

The manpower shortage in the provincial mental institutions is even more critical.[1] For the 5,274 patients in these institutions there are at present 7 psychiatrists employed, while 3 others are providing part-time service. The physician-psychiatrist : patient ratios recommended by the American Psychiatric Association Mental Hospital Services in 1954 were:

Admission and intensive treatment services	1:50 patients
Continued treatment service	1:150 "
Geriatric service	1:150 "
Medical and surgical service	1:150 "
Tuberculosis service	1:50 "

The present establishment of psychiatrists in these institutions is 19 giving them an overall psychiatrist : patient ratio of 1:277. While it is evident that, as a first step, the present establishment of psychiatrists for the Provincial Mental Hospitals needs to be doubled there will remain the problem of recruitment. In a recent analysis of the manpower situation published by the U.S. Department of Health, Education and Welfare - "Health Manpower: Perspective, 1967" - it is observed that "almost one-quarter of the available positions for physicians in mental hospitals are unfilled". This report also comments on one of the contributory factors - "The fact that a majority of psychiatrists prefer a full-time practice in big cities accounts in large measure for the great manpower shortage in public mental hospitals and community clinics".

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[1] This shortage has been magnified by the recent loss of several psychiatrists from Ponoka and the ratio of psychiatrists to patients is now much worse. WRNB

Patients in the mental hospitals receive only a small fraction of the care from psychiatrists that the same kind of patients receive in the psychiatric departments of general hospitals. For example, the 110 psychiatric patients in the general hospitals of Edmonton at any one time are attended by 19 psychiatrists, while for the care of the 1,200 patients there the Alberta (Mental) Hospital, Edmonton has been able to employ only 3. But recently, by inviting psychiatrists practicing independently in the City to take responsibility as attending staff for some of the patients, 3 have already been added.

The present grossly disporportionate shortage of psychiatrists serving at the mental hospitals, where there is by far the greatest concentration of severely mentally ill, could be eased, at least in the urban areas, simply by a change of government policy to put the mental hospitals under the same system of operation as general hospitals of the Province.

Under such a system, service in the mental hospitals would become much more attractive to the majority of psychiatrists who, like most other physicians, prefer independent practice (Ellis, 1966). Cognizance should be taken on the comment in the Report of the Royal Commission on Health Services - "In North America the traditional organization of medical practice is that of the independent physician operating under a fee-for-service system. The high degree of independence of the medical practitioner, whether he be in solo practice, in partnership, or in group practice, stems from the traditional belief that the individual is the really significant object of the service and that such service is the sole responsibility of the practitioner. The individual concerned, on the other hand, puts his physician in a position of special trust and confidence. This imposes a special kind of responsibility upon the physician." (Hall, 1964: 249).

While this change of system of operation could substantially ease the disproportionately great manpower shortage at the Alberta Hospital, Edmonton, it would not work at the Alberta Hospital, Ponoka in its rural setting without any concentration of psychiatrists in the vicinity. The solution there might lie in adopting a different system of operation, one which has proven effective elsewhere in Canada. That is for the hospital to function, not predominantly as a receiving service for patients but as a hub from which mental health services emanate widely throughout a surrounding territory. Then the necessary psychiatric consultant services to the "catchment area" would be provided by psychiatrists centred at the hospital but conducting a travelling consultant practice throughout a designated rural area.

With the vast extent of mental disability - roughly 50% of the nation's hospital beds being occupied by those totally disabled, acutely or chronically, by mental illness; one child in ten destined to need psychiatric treatment; 33% of all physical illness coming to the general physician being due predominantly to mental factors (Watts, 1952) clearly is an impossible expectation that enough psychiatrists could be mobilized to deal directly and individually with all the cases of mental disability in the community. This vast, unmet health need calls for the mobilization of a wide range of mental health personnel performing various different functions. It is of the utmost importance that the psychiatrist fulfills his optimum role in relation to other professional personnel. The need cannot be met by the psychiatrist functioning simply as a therapist-practitioner dealing individually and directly with all the cases of psychiatric disability. He could be much more effective if his chief function were to act as a consultant towards other categories of professional personnel - family physicians, nurses, clinical psychologists, psychiatric social workers, etc. Means must be sought to bring psychiatrists functioning as private practitioners more into the role of true consultants. This has implications for the training of future psychiatrists. This will be referred to later under the subsection of "Education and Training".

The quickest means of relieving the short supply of psychiatrists in Alberta is by recruitment from elsewhere. For this the incentives need to be strong and appropriately publicised. It has to be recognized that, so far, Alberta has not been as attractive as it deserves to psychiatrists as some other parts of Canada. Some of this is a matter of taste for climate, terrain, urbanization, cultural amenities, but more a matter of facilities available for and attitudes prevailing towards psychiatric practice in this Province. Because some of the reticence on these scores seems to be due to ignorance, there is a need for appropriate publicity. To this end the Government might consider establishing a service such as a Department of Development and Human Relations, perhaps out of the Council on Human Resources, to make the necessary effort to "put Alberta on the map" more impressively.[1]

Both the College of Physicians and Surgeons of Alberta and the Department of Health should display an encouraging attitude to all suitable enquirers. There have been in the recent past instances of well qualified psychiatrists enquiring about opportunities in Alberta who have been discouraged in their contact with officials of the Department of Health and the College of Physicians and Surgeons.

In considering remuneration as an incentive it is noted that the level of income in Alberta for psychiatrists in private practice compares favourably with that in other provinces, according to the fee schedules compiled by the provincial colleges. Remuneration on a salary basis according to the Civil Service schedule compares with private practice very unfavourably. Civil Service salaries across Canada for psychiatrists have undergone considerable escalation in the last few years with provinces competing vigorously with each other. Although in this Alberta does not compare unfavourably with many other provinces the escalation continues. For the Province of Saskatchewan the "Frazier Report" (1968) recommends a 25% increase in the Civil Service salary schedule, making starting salaries for psychiatrists from $17,000 - $30,000 per annum. While there will always remain certain roles for a psychiatrist in a psychiatric hospital which can be best remunerated on a salary basis, most of the discrepancy in monetary incentive for the provincial mental hospital and clinic services could be immediately overcome by a change of policy whereby most psychiatrists in their clinical work with patients would be remunerated on a fee-for-service basis through prepaid medical insurance plans. This would meet the expectations of psychiatrists not only with respect to the level of remuneration but also with respect to conditions of professional work and style of practice.

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[1] Alberta probably will remain off the map until an imaginative and more progressive mental health program has been introduced. WRNB

The incentives of income and conditions of work concern not only the prospect of drawing psychiatric personnel into the Province but also retaining for service in the Province those who are trained in their specialty locally. Of the 27 psychiatrists who have completed their specialist training in Alberta 14 of them have remained in practice in the Province. Of those who left one was considered undesirable and unwelcome. Of the 14 who have remained only 4 have continued in Civil Service employment, the rest having moved into the private practice pattern affiliating themselves with general hospital psychiatric services.

On the longer term, the means of relieving the short supply of psychiatrists is by producing them locally through graduate training programs.

Education and Training:

The University of Alberta graduate training program in the specialty of psychiatry commenced in 1957 with two trainees. As with other specialties in medicine the training takes four years. Two years are spent in a core program at the University and its affiliated teaching hospitals and clinics. A further two years training are provided through the Provincial Mental Hospitals and Guidance Clinics. At the present time there are 20 residency appointments available for the two-year core program. It is anticipated that this number could be increased by 10% - 20% each year over the next few years and, with the opening of the proposed Day Hospital in the Ambulatory Care Facility of the Health Sciences Centre, another 10 - 14 positions could be provided. Thus, with the present facilities and arrangements psychiatrists could be qualified through this program at the rate of 10 per year, increasing by 10% - 20% in subsequent years.

For this program in its present dimensions there should be available in the Provincial Mental Hospitals and Guidance Clinics an equal number of positions, i.e. 20. Not only are these positions required for training but also this arrangement would contribute substantially to the number of psychiatric staff so much needed at present in these facilities.

The University of Calgary plans within the next few years to develop a similar postgraduate training program in psychiatry, thus providing a further source of qualified psychiatrists.

However, there is at present and has been for several years a great dearth of candidates for the residency positions available. This pertains throughout the North American Continent. The situation in Canada is comparable to that in the United States where there are at present 1,000 vacancies for residency training in psychiatry. The corresponding figure for Canada is not obtainable though the projection of the dearth in the U.S. would suggest a figure of 100 vacancies in Canada.

In Alberta this year there are thirteen acceptable candidates for the twenty positions that could be available. This number of thirteen, however, represents an 80% increase over the previous year.

To meet this situation of dearth in applicants for specialty training in psychiatry, as compared with some other specialties such as obstetrics and gynaecology, general surgery, and internal medicine, where almost a surfeit of these specialists exists, at least in the urban areas, it is recommended that the Medical Schools be urged to ensure that undergraduate medical students be properly orientated towards the relative needs of the community for specialists and that the Department of Psychiatry intensify their efforts to induce graduating students to consider specializing in psychiatry. The practice of offering to medical students summer interneships at the provincial mental hospitals is to be commended and encouraged.

Psychiatry, neuro-psychiatry, paediatric psychiatry and neuro-surgery were singled out by the Royal Commission on Health Services for special consideration. Specifically for these specialties it was recommended "that as part of a seven year crash program, professional training grants of $5,000 per year be made to medical graduates preparing for their specialist certificate (Hall,1964: 22).This recommendation is strongly endorsed in principle by our committee, although the amount of the grant (5,000) is probably now inadequate for the purpose.

The present University of Alberta graduate training program in psychiatry and the future University of Calgary graduate training program in psychiatry should ensure that their trainees are orientated towards the changing role of psychiatrist to better meet the needs of society today - notably the change from the therapist-practitioner role to that of consultant to the family physician and the various professional personnel inevitably involved in mental health care.

FAMILY PHYSICIAN[1]

Much thought has been given to the importance of the role in mental health of the Family Physician in Canada. The Royal Commission on Health Services stated, "The increased awareness of psychiatric symptoms by the physician and the public has stimulated attempts to integrate psychiatric services into the main stream of health services with the general practitioner playing a vital role in the early diagnosis and treatment of these disorders. The increasing emphasis on the social as well as the medical rehabilitation of the patient has reinforced the need for a general practitioner with his knowledge of the patient's social environment. The growing knowledge of the importance of social factors in health and illness have served to highlight the continuing care of the whole patient with the general practitioner as the key figure in this arrangement." (Hall,1964: 241).

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[1] A detailed brief by Dr. E.R. Haynes, prepared as part of this study is presented in its entirety in Volume 2. WRNB

In the section on Medical Education of Canada of the Report of the Royal Commission on Health Services (the MacFarlane Report) it is stated that "the development of personal physicians will reduce the load on the specialist-psychiatrist and permit him to confine his activities to consultant practice." (MacFarlane, 1965: 144).

The University of Saskatchewan psychiatric group under the leadership of Dr. D.G. McKerracher has given much study to the question of the role of the family physician in mental health. They have come to the conclusion that the most feasible and effective means of providing more mental health care is through family physicians adequately trained in psychiatric medicine with consultative support from psychiatristsoriented to their role essentially as consultants.

A pilot project was undertaken by this group to study the feasibility of general practitioners themselves managing the full range of psychiatric disorders presenting to them in their community while using a psychiatrist only as a consultant. Thus they attempted to treat all the psychiatric patients themselves rather than passing them over to the psychiatrist. The study confirmed the feasibility of the procedure. (McKerracher, 1965: 1005-7).

"The American Medical Association and its Council on Mental Health have labelled mental illness as America's most pressing and complex health problem, and the Association has given the Council a mandate to develop and implement a realistic, positive program, stressing the important stake every physician, regardless of type of private practice, has in improving our mental health knowledge and resources", wrote Drs. Farnworth and Rome in 1964 in the Journal of the American Medical Association. (p. 159).

This committee strongly endorses the concept of the family physician as playing a key role in mental health care. The great majority of cases of psychiatric disorder, minor or major, are presented initially to the family physician. The diagnosis and management of most of these can be well within the capabilities of the appropriately trained family physician without requiring a great deal of specialized knowledge.

But in the last three decades the proportion of family physicians has been progressively and drastically curtailed. The proportion of physicians who choose to go into family practice or to stay in it has rapidly declined. Two different attitudes are prevalent in the medical profession. One deplores this manpower decline and urges that appropriate steps be taken to encourage more medical graduates to go into family practice. The other accepts the decline as an inevitable trend in modern society moving towards specialization and assumes that the function of the family physician will succumb to the development of team or group practice.

In 1955, when the population of Canada was 15,698,000, there were a total of 14,660 doctors in medical practice of whom 9,818 were general practitioners and 4,842 were specialists. Thus, 2 out of 3 were in general practice. Ten years later in 1965, when the population had grown to 19,455,000 and the number of doctors to 19,644, there were 10,221 in general practice and 9,423 specialists. This meant that there had been a 94.6%

increase in the number of specialists and only 4.1% increase in the number of general practitioners over a period when the population of Canada had increased 18 percent. In 1931, 84% of all physicians in private practice reported themselves to be general practitioners. In 1960 the corresponding percentage was 45 and in 1965, 37. (Perkin, 1967: 1569).

The Royal Commission on Health Services reported that "it is generally agreed that even with all the advantages of modern specialism, both in the fields of diagnosis and curative medicine, 50% of those licenced to practice would be needed in the family, general, or what might be more aptly called "personal practice". (MacFarlane, 1964).

Because the family physician occupies such a strategic position for mental health and because mental illhealth is such a huge, pressing problem, every possible encouragement should be given to medical students to take up family practice and to family physicians to remain in that practice. Unfortunately, in the eyes of the medical profession at large the image of the family physician has become less attractive in recent years. Steps should be taken to improve this image and increase the incentives towards family practice. The recent establishment of Colleges of Family Practice has served to improve the image. The College of Family Practice in Alberta should be warmly supported in this endeavour. The medical schools are in a very influential position in this regard. While doubt has grown in the minds of medical educators about the importance of the family physician in the future methods of health care with the increasing reliance on elaborate specialization in physical methods, the importance for mental health of a family physician is patent. The Medical Schools of Alberta could and should assume more responsibility to clarify in the minds of medical students the particular importance of family practice.

To encourage the development of medical schools in the direction of Family Practice, two recommendations of the Royal Commission on Health Services (Hall, 1965:245-6) should be implemented, namely:

> #228 "That the Association of Canadian Medical Colleges, in consultation with the College of General Practice of Canada and others concerned give immediate attention to the question of setting up administrative Departments of General Practice in the teaching hospitals and subsequently, Chairs of General Practice in the Faculties of Medicine."
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> #229 "That, as part of a seven-year crash program, special Professorial Training Grants of $5,000 per year be allocated to medical graduates undertaking postgraduate study to qualify for the teaching of general practice in the Faculties of Medicine."

The teaching programs of medical schools generally have in the past provided insufficient basic knowledge and practical training to prepare medical students to deal adequately with mental disorders that, in major or minor degree, comprise a large proportion of illness.

In the study of Gilbert (1964) "A Preliminary Report on the University of Alberta Medical Graduates", the recommendation most frequently made by the graduates about their medical school training was that more time and attention should be devoted to specific general practice training. Also high on the frequency list was the expression of need for more training in psychiatry. (p. 826-830).

Recommendations to medical schools in general have not been lacking:

Donald Rice, in a paper on "The Education of the Family Practitioner" in 1968, said, "With respect to the core content of family medicine, we believe that the family physicians should have a firm grounding in the basic behavioural sciences, a broad knowledge of medicine, extensive training in internal medicine, selected training in each of the specialties and special training in psychosocial medicine."

In Undergraduate and Postgraduate Training in Psychiatry, (1965 : 41), Martin states, "The teaching of psychodynamics at the undergraduate level is one of the most important although one of the most neglected aspects of medical education. I take it to be important not simply, nor indeed primarily, because of its value to those who will eventually proceed to specialization in psychiatry, nor because of its contribution to the student's progress in his psychiatric term. I take it to be important because I believe that an adequate appreciation of, and competence in the handling of psychodynamics, is an essential requirement for the general medical practitioner. It is especially important at the present time because of the increased recognition that the massive task of dealing with the problem of mental illnesses beyond the capacity of the specialist psychiatrist and must be dealt within preventative and prophylactic terms by the general practitioner." This Committee strongly endorses this opinion.

Kiloh (1965 : 82) in Undergraduate and Postgraduate Teaching in Psychiatry states, "It is sometimes overlooked that about 50% of our graduates are destined to become general practitioners, and for many of these opportunities for postgraduate study are likely to be limited. For this reason, and because it is not only undesirable but impossible to train an undergraduate to become a psychiatrist, I feel undergraduate psychiatric education - which at best can serve only as an introduction - should be designed largely in accord with the needs of general practice."

Recommendations as to premedical curricula also have been made. For example, the MacFarlane Report on Medical Education in Canada of the Royal Commission on Health Services, 1965, recommended that "Medical Schools should begin to enquire more closely into the recommended pre-professional education of candidates who expect to enter medical school and to recommend such courses as are available and relevent in social sciences. The possibility of establishing in faculties of arts and science special combined honour courses in the social sciences and in the natural sciences should be explored."

While such efforts would be directed towards inducing more medical graduates to go into and remain in family practice equipped to make optimum use of the strategic position of the family physician with respect to mental health care, there remains a formidable need for postgraduate education of physicians presently in family practice. Most of these in graduating from medical schools have not received adequate training in psycho-social medicine which occupies so large a portion of family practice. There is a great and urgent need for postgraduate courses in psychological medicine (psychiatry) for practicing physicians. In the United States quite vigorous efforts have been made by the National Institute of Mental Health, the American Academy of General Practice and the American Psychiatric Association through its Committee on Psychiatry and Medical Practice. (Branch; Nicholas, 1965 : 485-9). For several years short courses lasting a few days each have been offered in many parts of the country. The United States Government has allocated large sums of money to establish postgraduate training programs in psychiatry for general practitioners. In 1965, for example, the sum of $7,000,000 was allocated through the National Institute for Mental Health for this purpose. If this sum were extrapolated per capita to the Province of Alberta this would mean an annual expenditure for this purpose of some $50,000. This Committee would recommend that such funds be provided for this purpose in line with the recommendation (#5) of the Royal Commission on Health Services (1964 : 22) that: "Medical Schools be granted funds to conduct special courses in psychiatry for general practitioners."

> Medical Schools, then, should be urged to give further heed to the recommendations of the Royal Commission on Health Services and make the necessary innovations in their teaching programs so as to produce a greatly increased number of family physicians prepared to deal effectively with most of the serious psychiatric disorders of the community. This should entail providing adequate basic instruction and practical training in the behavioral sciences, as recommended by the Endicott House Summer Study on Medical Education (Cope, 1966: 87)
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> > "The practice of medicine as an applied science depends on the basic psychological and social sciences in exactly the same sense that it depends on the biologic sciences. The conference recommended that the policy adopted for the biologic sciences could be equally well applied to the behavioral fields."

Postgraduate courses on a large scale should be set up for family physicians presently in practice to provide them with the theoretical and practical basis necessary for the practice of psycho-social medicine to make good what was lacking in their earlier basic medical training. Grants-in-aid should be provided to such physicians to compensate them for the inevitable loss of remuneration incurred by taking the requisite amount of time off from their practice for this educational purpose.

In addition, the medical schools should set up substantial programs of continuing medical education for family physicians for the constant up-dating and stimulation of their interest in the psycho-social aspects of medical practice.

PSYCHOLOGIST[1]

The psychologist has a unique role to assume in mental health as a consultant and practitioner in three areas: assessment, treatment and research, both evaluative or applied and basic research.

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[1] A brief by Prof. A.J.B. Hough of the University of Alberta, and a member of this Study Group on Manpower, Education and Training, is published as part of Volume 2 of this report.

Of the 62 psychologists registered and resident in Alberta very few are engaged directly in mental health care. Many of them are following academic pursuits as members of staff at the universities, some are in postgraduate studies, and many do not have a primary interest in the applied field of clinical psychology. Only 10 are in the employ of the Department of Health for service in the Provincial mental health facilities.

The scarcity of psychologists, qualified to work in these clinical settings, had led to the employment of inadequately trained personnel as substitutes in a number of psychology positions. In the Provincial mental health facilities, for example, there are 49 personnel filling "psychologist" positions but, of these, only 10 are qualified.

"Qualified", in this respect, means having an appropriate university degree and being registered with the Psychologists' Association of Alberta, the legally authorized body for this purpose. The minimum legal requirement for being registered as a psychologist in Alberta is a Master's degree. It should be noted that several provinces in Canada and numerous states in the United States set the Ph.D. degree as the minimum requirement for professional membership. There is currently in Alberta a body of opinion in favour of moving in this direction to upgrade the qualifications to the doctoral level. That development is supported by this Study Group.

There are two major factors bearing upon the critical shortage in Alberta of psychologists for mental health service. One has to do with the inadequacy of appropriate training facilities; the other with remuneration.

The profession of psychology and university departments of psychology generally have adopted a scientist or scientist-practitioner model for the education and training of psychologists. While academic psychology with this orientation has flourished, there has not been a corresponding development in applied areas sufficient to meet the manpower shortage in the mental health field. Mental health facilities of Alberta offer some opportunity for "internships" and "in-service training" but they have not been utilized fully. The Department of Psychology at the University of Alberta is about to set up a program to help meet the need for more clinicians, utilizing those clinical facilities. This endeavour should be supported by the Government, in part through encouraging joint appointments between teaching departments and the staffs of mental hospitals and guidance clinics.

The Department of Psychology at the University of Calgary has a three-year old program of practicum training for graduate students at the Alberta Hospital, Ponoka and the Alberta Guidance Clinic, Calgary. That program merits support and extension. Financial support, however, should not be confined to institutions operated by the Provincial Government. Suitable practicum training settings already exist at the Foothills and the Calgary General Hospital. The senior psychologists at Foothills and the Alberta Guidance Clinic already hold academic appointments in the Department of Psychology, University of Calgary; the practice should be extended.

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[1] It must be emphasized that competent supervision in "field" settings is fundamental to the practical training of psychologists. A profitable investment for the Government could be realized through the recruitment of Ph.D. psychologists for existing public facilities, thus providing practical training settings which are up to a national standard. WRNB

To provide special incentive for university graduates specializing in clinical psychology the recommendation made by the Royal Commission on Health Services (Hall, 1964) should be implemented, "That as part of the same crash program, professional training grants of $3,000 a year be made available for university graduates specializing in clinical psychology"(p. 22). Because of the economic changes since this recommendation was made the specific amount of the grant would now be inadequate.

The salaries offered for psychologists in the mental health field compare favourably with those in some other provices but are far from competitive with remuneration offered in academic settings, private agencies and private practice.

It is noteworthy in this connection that the "Frazier Report" recommended an improved salary schedule for psychologists in Saskatchewan. Similar revisions to the Alberta schedule were made in 1968.[1]

It is recognized that there is a useful role in the mental health field for persons with appropriate psychological training below the Master's or Doctoral level. They can render a uniquely useful service in the application of psychological tests of personality or behaviour provided that they are under the supervision and direction of qualified psychologists. It has been the practice in the past in Alberta, as elsewhere, for such persons (more appropriately to be called "psychometrists" or "psychological technicians", to distinguish them from qualified psychologists) to function without adequate supervision and to assume professional responsibilities for which they are not qualified. Noteworthy progress in organizing psychological services to make proper use of psychometrists or psychological technicians under adequate supervision has been made in the Province of Ontario. University and, possibly, technical school training programs in psychology are needed to prepare such "psychometricians" or "psychological technicians".[2]

For the purpose of properly utilizing the services of psychometrists[3] or psychological technicians and organizing psychological services attractive to other qualified psychologists, it is recommended that a position for a Ph.D., clinical psychologist to serve in a supervisory and educational capacity, be provided at each of the mental hospitals and major guidance clinics.

To develop adequate psychological services within the Department of Health, it is recommended that a post of Advisor in Psychology by created and filled by a broadly trained psychologist with both clinical and relevant research experience.

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[1] The Alberta schedule is still well below the level required to attract Ph.D. psychologists. Now established at $10,380 - $13,080, it would have to be raised to $14,000 - $20,000 if suitable senior personnel are to be attracted. WRNB

[2] A complete set of job specifications for psychologists and assistants, prepared by R.G. Berry, a consultant to the Study, is published in Vol. II. WRNB

[3] The Department introduced the category of psychometrist in February 1969. WRNB

There has been in the United States in recent years a trend towards psychologists functioning as "private practitioners". This trend is in evidence in Canada but to a much lesser degree. In so far as this practice has to do predominantly with problems of mental health is it important that psychologists practicing thus independently be very well qualified. To this end it is recommended that the Psychologists' Association of Alberta recommend to the Provincial Government that the "Psychologists' Act" be amended to the end that a doctoral degree in psychology will be the minimum legal requirement for this form of practice.

School Counsellors and School Psychologists

Another area of concern of great importance to mental health, particularly with respect to primary prevention and early case finding, is the schools. This Committee is of the opinion that there is a great need to increase psychological consultation through psychologists to teachers, to students and to parents. Required is a great intensification of training of psychologists for this service and provision by school boards to employ them in much greater numbers.

The School Counsellor is in a front line position to render primary prevention service. Under his purview are all children in the school; not only those with serious problems.

Unfortunately it has been a frequent practice to assign to this special function of "school counsellor" teachers who are not specifically trained for it. In the school systems of the Province of Alberta there is considerable obscurity as to which staff members should be regarded as counsellors. And there is obscurity, too as to what guidance and counselling actually involves in the school situation. Statistics from a Canada Manpower Study "Career Decisions of Canadian Youth" Vol. 1, published in 1967, however, provide some illumination: Twenty-seven per cent of the teaching staff of Alberta schools is involved to some extent in guidance work of some kind. Much of this is group guidance or instruction, less is individual counselling. Fifty-three per cent of those engaged in guidance work in Alberta devote less than one hour per week to it. Eighty-one per cent of those engaged in guidance work in Alberta have no certificate, diploma or degree in guidance. Ninety per cent of Alberta school principals engage in guidance work, and of these ninety-one per cent have no certificate, diploma or degree in guidance work.

According to the report, fifty-nine per cent of Alberta teachers and counsellors think that the number of guidance personnel in their schools is insufficient; and eighty-two per cent of the principals think this. Fifty-seven per cent of Alberta principals think that time devoted to guidance in their schools is inadequate, and seventy-four per cent of them think their facilities and equipment available for guidance are inadequate.

Obviously a much larger number of appropriately trained counsellors is required to staff Alberta schools. The University Faculties of Education, through their Counsellor Education Programs, should provide appropriate basic courses and "continuing education" courses for school counsellors.

Bursaries offered by the Department of Education would provide an incentive for teachers to take this training. To increase the likelihood that only trained people will be employed by school boards the Department of Education should continue the system of providing a $1,500 grant to school boards for every counsellor who devotes more than two-thirds of his time to counselling. It is recommended that these grants be made only on behalf of counsellors who are certified. Certification need be no major problem, as at present there is in this Province a professional group, the Guidance Council of the A.T.A., which could readily take responsibility for certification of counsellors.

School Psychologists in Alberta usually have training to the Master's level, either in Education or in Arts, with other courses to sufficiently merit a teaching certificate. They may function as psychometrists as well as psychologists. They often provide most of the liaison between the school, parents, social agencies and other public groups concerned. They are usually responsible for individual testing which may determine special class placement for a student, are responsible for the recognition and diagnosis of problems that may require referral for treatment, and act as the interpretive agent between the school and any outside social agency. They are readily-available consultants to the classroom teacher, interpreting the behaviour of students and offering suggestions for management. They frequently serve as co-ordinators of professional services to students, e.g. those of the school nurse, the attendance officer, the speech pathologist, etc.

While most urban school systems employ school psychologists, few rural systems do. A revision of the grant policy of the Department of Education is required to extend psychologists' services to all schools in the Province.

The present policy of the Department of Education to subsidize for only those psychologists who hold a teacher's certificate must place unjustified restriction of providing proper psychological service. The policy is evidently based on an assumption, which is not substantial, that a teaching certificate is a necessary qualification for a psychologist practicing in a school setting.

To provide for school children adequate psychological services, which are of the utmost importance in primary prevention and early case finding, a vastly increased number of psychologists is urgently required.

SOCIAL WORKER[1]

Of the 3,000 social workers in Canada 200 are practising in Alberta. Most of these perform functions only indirectly related to mental health - probation officers, marriage counsellors, youth workers, community organizers, public welfare workers, administrators, etc.

Traditionally in mental health services the social worker has been allotted an important place. The social worker in a mental health team plays a key role in diagnosis by making assessments of family or other environmental situations, and in treatment by dealing with family and social conflicts, in after-care of patients discharged from mental hospitals, and in certain cases in taking leadership in group therapy.

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[1] A brief by Mr. G. McLellan, President of the Alberta Division of C.M.H.A. appears in Volume 2 of this report. WRNB

The supply of qualified social workers, in Alberta as elsewhere in Canada, falls far short of the demand. Statistics indicate that the number of social workers qualifying from the professional schools is not appreciably exceeding the loss by deaths and discontinuation of practice.

There are nine schools of social work in Canada, one being in Alberta. That social workers generally are in such short supply is due not immediately to the lack of training facilities but to the lack of applicants for them.

A conservative estimate of the need for qualified social workers to staff the Mental Hospitals and Guidance Clinics of the Division of Mental Health at their present level of operation would be 35, more than double the present number, provided that an equal number of social work aides were employed to work with them. The greatest proportional need for social workers is at the two mental hospitals, where only two qualified social workers are presently employed at one and none at the other. There are ten other personnel with baccaulaureate degrees but unqualified in social work who are carrying out social work duties. On the staff at the two Provincial Guidance Clinics at Edmonton and Calgary there are presently sixteen social workers and eighteen others unqualified.

Because of the shortage of qualified social workers it has been the practice to employ as social workers personnel without adequate or formal training. There are in mental health services many tasks in the general area of social work that can be adequately carried out by personnel without the formal qualification of social worker. Because of the great shortage of social workers the deployment of such personnel is to be encouraged. They should always be deployed in situations where they are under the supervision of qualified social workers.

Universities, particularly through their schools of social work, should offer appropriate training programs to prepare personnel as social work aides, child care workers, welfare workers, etc. Such training programs should be encouraged and supported by all possible means.

To increase the incentive for professional social worker training it would be important to implement the recommendation of the Royal Commission on health services (Hall, 1964:22)"as part of the crash program professional training grants be offered to candidates proceeding towards their social work qualification." The amount of the grant ($3,000) recommended would need to be increased now in view of the changed economic situation since the time the original recommendation was made.

To aid particularly in solving the manpower problem with respect to social work a highly qualified and experienced social worker is needed as a consultant to the Division of Mental Health.

Wide and intensive publicity of the need and the opportunities for professional social workers might well be directed through the Public Information Service to high school graduates and to baccaulaureate university graduates to induce their moving into this field.

NURSE[1]

In mental health care the need and opportunity for the nurse's skills, participating with the doctor both through diagnostic observation and psychological therapy, are so great as to make psychiatric nursing a particularly challenging field. For psychiatric patients in hospital the nurse is often the mainstay of treatment. Beyond the hospital itself the psychiatrically trained nurse can render a valuable service as a community nurse by home visitation in the follow-up care of psychiatric patients after discharge from hospital. She also provides a unique preventive service through home visitation to detect the early signs of emotional or mental disorder in the family.

There persists in Alberta, as in Canada generally and in the United States, a general shortage of nurses, although the ratio now of nurse to population in Canada, 1: 164, is the highest yet attained in Canada and one of the highest in the world. But there appears to be a marked decline in incentives towards the profession of nursing. In 1940, 25% of the students graduating from Canadian high schools enrolled in schools of nursing. By 1950 the percentage had declined to 20%. By 1960 it had declined to 10%. The trend would appear to continue.

The total number of registered nurses bears no significant relationship to the number available for mental health (psychiatric) care. The programs of schools of nursing for registered nurses do not prepare the graduates sufficiently to practice psychiatric nursing or mental health care. The two months of psychiatric nursing experience in the basic nursing programs is little more than a beginning development of the necessary clinical skills.

The registered nurse who by extra training is qualified as a public health nurse, although in the best position to serve as a community nurse for mental health care, is not adequately oriented or prepared in interviewing, counselling, or in the knowledge of mental disorders.

To meet the need for nurses psychiatrically trained for mental hospital care special courses were provided at the provincial hospitals in Alberta as in other Western provinces. The graduates were equipped to carry out nursing procedures traditional just to these institutions. This led to a separate category of nurse - the registered psychiatric nurse - although this qualification was recognized only provincially, not nationally. These nurses, given a certain amount of reorientation, can adapt fairly well to the care of patients in psvchiatric units of general hospitals. In Alberta the registered psycniatric nurse has not been readily accepted on the staff of general hospitals and not classed with the registered nurse with respect to level of remuneration or degree of authority. Only just recently have registered psychiatric nurses been employed by three Alberta hospitals (The University of Alberta Hospital, the Foothills General Hospital, and the Glenrose School Hospital).

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[1] Briefs submitted separately by the Alberta Association of Registered Nurses, the Psychiatric Nurses Association of Alberta and the Victorian Order of Nurses are published in Volume 2 of this report. WRNB

At the mental hospitals there is a serious manpower shortage for psychiatric nursing. Not only is there a great shortage in numbers of nurses but also a great inadequacy of appropriate training. In a study undertaken at the Alberta Hospital, Edmonton, in December, 1965, it was shown that a safe level of nursing care on the average on each ward unit would be 2.5 hours of care per day. This figure was in accord with the recommendations of the American Hospital Association and the United States Public Health Service. But at the time of this study the number of professional nursing personnel could provide only 1.4 hours of care per patient day. More recent figures (May, 1968) for this same hospital show that there were 62 vacancies in an establishment of 241 for graduate nurses (R.N.s and R.P.N.'s). There were 35 vacancies for an establishment of 131 psychiatric student nurses. The shortage of ancillary nursing personnel - certified nursing aides, ward aides, and institutional attendants - was proportionally not nearly as great - 10 vacancies in an establishment of 131. At the Alberta Hospital, Ponoka, there were 37 vacancies in an establishment for nurses (both R.N.'s and R.P.N.'s) of 182. For the total establishment for nurses at the Provincial Hospitals at Edmonton, Ponoka, Raymond, Clareshome, Camrose and Red Deer of 335 there is a shortage of 84.

To meet the need for nursing care at the Provincial School Hospital, Red Deer, an in-service training program has been devised giving local recognition to those successfully completing the course as "Mental Deficiency Graduate Nurses". There is at present an establishment for this category of personnel of 121. Against this establishment there is a shortage of 46. There are, however, 152 employed for nursing duties while nominally enrolled in the training program. The preparation of this "nurse" is limited to service in that particular institution.

As standards for nursing care in mental hospitals the American Psychiatric Association (1954) recommended the following registered nurse : patient ratios:-

Admission and intensive treatment service	1 : 5
Continued treatment service	1 : 40
Geriatric service	1 : 20
Medical and surgical patients	1 : 5
Tuberculosis service	1 : 5

The Sub-Committee on Psychiatric Nursing (Chairman, Dr. J.E. Bradley) of the Committee on Professional Hospital Relations (1965) conducted a thorough study of the nursing manpower situation in the mental hospitals and recommended a considerable increase in the nurse : patient ratio. (p.8).

Not only is there a considerable proportion of untrained personnel attempting to provide care for the mentally ill in the mental institutions in Alberta, but also nurses holding senior positions are often not those with advanced preparation in psychiatric nursing, supervision, administration or nursing education. Seniority in terms of years of service rather than qualifications appear to be the criteria upon which personnel are appointed to the senior positions.

The comment made by Maxwell Jones (1964) on psychiatric nursing in the United States might be applied to Alberta - "It is difficult to believe that an informed public can much longer tolerate nursing care of the mentally ill which compares so unfavourably with the nursing attention afforded to the physically ill." (p.104).

Quite apart from the need for adequate psychiatric nursing in the hospitals is the need for community mental health nursing. With the realization of the great importance for mental health of community care through home visits, outpatient clinics and day hospital services, the importance of the community nurse looms large. The public health nurse, under present training programs, is not adequately prepared for this role in mental health care. While the training of registered psychiatric nurses renders them better prepared for dealing with the mentally disordered person it is inadequate preparation for the nurse to function in the community. The public health nurse, given additional training in mental health, and the registered psychiatric nurse, given more of her psychiatric training in a community setting, could assume uniquely useful roles as community mental health nurses.

At present there are virtually no home-care programs for mental health in Alberta, while in the neighbouring province of British Columbia home-care programs through provincial health units are available to over 80% of the population. (B.C. Department of Public Health, 1966, p. 15).

Home visitation can serve not only for the follow-up care of psychiatric patients discharged from hospitals, but also for early case finding. While the family physicians may perform this function to some extent, the public health nurse having special concern with mental health could assume much of this responsibility in primary prevention.

There is a multiplicity of training programs for nursing in mental health care. They range from a 2-month segment of experience for nursing students in general hospitals proceeding towards their R.N. qualification, to a 3-year program at mental hospitals for students proceeding towards the R.P.N. qualification. There is a combined R.N. course of 4 years duration offered by one of the Provincial Mental Hospitals (Ponoka). There are postgraduate courses for R.N.'s offered at the mental hospital. There are informal and loosely structured courses of instruction for public health nurses. There is a 2-year course (formerly 3-year) at the Provincial School Hospital, Red Deer, for a "Mental Deficiency Graduate Nurse" certified by the Department of Health. Although there is a common purpose to all of these programs there is no over-all coordination of them. Clearly, one of the fundamental needs is for coordinated planning of all of these educational programs. A central planning body consisting of representatives of education, hospitals and other health services, and the public to be served is a primary necessity. To this end it had been recommended in the report of the Sub-Committee on Psychiatric Nursing of the Canadian Medical Association that an Alberta Council of Nursing be set up under charter to be responsible for the licencing of all categories of nursing personnel and for the coordination of educational programs. (Bradley, 1965, p. 13).

There is a great and urgent need for a post-basic program in psychiatric nursing for R.N.'s and public health nurses, this should be done most suitably by the School of Nursing at the University of Alberta.

Special inducement for registered nurses to take such a course either in Alberta or elsewhere should be provided through attractive grants and bursaries offered by the Department of Health.

The need for the special programs for psychiatric nurses offered in the four Western Provinces was expected, by the Royal Commission on Health Services (Hall, 1964: 64) to end. The Canadian Nurses' Association has recommended that they be phased out as more adequate instruction in psychiatry is included in the basic curriculum for registered nurses. However, the need for nurses with such training as these programs offer is so pressing that they should not be discontinued until a more adequate program is substituted.

As a means of accelerating training for psychiatric nursing it would appear feasible without lowering essential standards to shorten the present psychiatric nursing programs at the two Provincial Mental Hospitals to two years. Similarly, the present 4-year combined course at the Alberta Hospital, Ponoka, could be shortened to three years.

It would also seem desirable that post-secondary educational institutions provide programs for supplementary courses in nursing which would enable the registered psychiatric nurse to meet the requirements for the R.N. qualification and thus to be eligible for entrance into the School of Nursing at the University of Alberta.

Seeing that there are at present a variety of ancillary nursing personnel - attendants, nursing orderlies presently being trained at the School for Nursing Orderlies, nursing aides, some trained at the Nursing Aide Schools at Calgary and Edmonton - it is important that all such categories be trained in vocational or technical schools. The training in patient care for such personnel should come under a Director of Nursing Education appointed at each of the Provincial Mental Hospitals and Institutions.

It would be important at all of these institutions for there to be organized educational programs for the continuing education of nursing and ancillary nursing staff to ensure that their knowledge and practice is progressively updated.

The training program at the Provincial School Hospital, Red Deer, which was devised in an attempt to meet the shortage of personnel for nursing care, should come under the central educational body and eventually be transposed into a vocational program to merit wider recognition.

The need to provide adequate incentives for nurses to move into the mental health field is a matter for serious consideration. The matter has been carefully studied by the Sub-Committee on Psychiatric Nursing of the Canadian Medical Association's Committee on Professional and Hospital Relations (Bradley, 1965:13). Their recommendations merit full consideration. Salary incentive needs to be reconsidered. It is noteworthy that the "Frazier Report" recommends considerably increased salaries for nurses. Salaries for registered psychiatric nurses have, in Alberta, been less than for registered nurses. It should be recognized that psychiatric nursing calls for special skills which on the whole tend to be more exacting than those for general nursing. Reconsideration would probably lead to at least equalizing salaries for registered psychiatric nurses with those of R.N.'s. It could be well argued that a differential in favour of the well qualified psychiatric nurse would be justified.

With the critical nursing shortage it is important to ensure by efficient administration that the optimum use is made of the special psychiatric nursing skills. As in general nursing, deploying highly trained personnel on tasks that could be done by those with lesser training has to be carefully avoided. With the judicious placement of well-qualified personnel the optimum use can then be made of ancillary personnel.

To this end a highly qualified psychiatric nursing consultant should be employed by the Department of Health and advisors should be made available to all the mental hospitals in an attempt to ensure that qualified nurses are deployed in the most effective way appropriate to their qualifications.

Similarly, psychiatric nurse consultants should be available to the nursing staff in general hospitals, auxillary hospitals, nursing homes, public health agencies, and mental hospitals in the care of the mentally ill.

New ground needs to be broken to institute community mental health nursing. Reference has been previously made to the need for a community orientation in the training of registered psychiatric nurses (or additional training in community nursing for those already graduated) and to programs of additional training in mental health for public health nurses. Such nurses should then be attached to the Regional Public Health Units as their base for home visitation and clinic service (Turner et al, 1967, 1322-6).

For effective community nursing for mental health there needs to be greatly improved communication between family physician and the public health unit staff and, in cases where the Provincial Mental Hospital has been used, between the hospital's staff and the family physician or the public health unit staff. The follow-up care of patients returning to rural areas after discharge from the mental hospital can often be carried out most appropriately by the public health nurse, provided that there is adequate communication from the hospital by arrangement with the family physician.

Finally, there needs to be set up a research and planning council to develop, for one thing, a multi-disciplinary approach to research in nursing practice for mental health.

OCCUPATIONAL THERAPISTS AND RECREATIONAL THERAPISTS

Professional occupational and recreational therapists are essential members of the team of professionals required for comprehensive mental health care in all hospital and day care services.

There is a great shortage of qualified occupational therapists in Alberta as elsewhere in Canada.

At the time of this report there were the following numbers of qualified occupational therapists in psychiatric service at the various hospitals. They are listed against a rough estimate of the numbers needed:

Hospital	Employed	Needed	Shortage
Alberta Hospital, Edmonton	1	12	11
Alberta Hospital, Ponoka	-	12	12
Rosehaven, Camrose	-	6	6
Red Deer	-	10	10
Alberta Hospital, Clareshome	-	6	6
Alberta Hospital, Raymond	-		1
Alberta School Hospital, Red Deer	-	12	12
University of Alberta Hospital	2	5	3
Royal Alexandra Hospital	1	3	2
Misericordia Hospital	-	3	3
Glenrose Unit for Emotionally Disturbed Children	2	2	-
Totals	6	72	66

A small number of persons are employed in the psychiatric hospitals as unqualified occupational therapists. For example, at the Alberta Hospital, Edmonton, there are 6 such persons.

There is a useful place for occupational therapist aides working under the supervision of qualified occupational therapists. The recommended ratio is 2 aides to 1 qualified occupational therapist.

The present course in occupational and recreational therapy offered at the University School of Rehabilitation Medicine appears to provide students with insufficient practical training in dealing with mentally and emotionally disturbed patients. Attempts should be made to provide this needed instruction through collaboration with the University Department of Psychiatry and the Provincial Division of Mental Health. While the Alberta Hospital, Edmonton, provides ample opportunity for this practical experience for occupational therapy students it cannot be made use of for lack of qualified occupational therapists there to act as supervisors and instructors.

OTHER CATEGORIES OF MENTAL HEALTH PERSONNEL

Aides to Professional Personnel

In all the various categories of mental health related personnel that have been so far discussed in this report there has been some suggestion of functioning at less than the optimum as a result of confusion of roles. The psychiatrist, attempting to meet the demands thrust upon him, is sometimes performing tasks which do not call for his special talents, tasks which could be performed with less elaborate or different training. The same can be readily said of psychiatric social workers and nurses. Hence, there have evolved other categories of health personnel to act as aides or auxillaries - nursing aides, ward aides, attendants, child care workers, social and welfare counsellors, etc.

The concept of the aide or auxillary in health care has developed and gained much favour. It has extended, more in theory than in practice, to some new categories of personnel. Serious consideration has been given to the concept of the feldscher now in practice as an assistant to the physician in the Soviet Union.

Specifically in the area of mental health care there had been created in Great Britain a category, though of very limited function, in the Duly Authorized Officer whose responsibilities are simply to facilitate the admission of certifiable patients to custodial psychiatric facilities. This is mentaioned as an example of an additional category, not to be recommended in the current situation as it is in Canada.

Because of the great dearth of professionally qualified personnel in all regular categories in the mental health services at the present time much consideration has been given by this Committee to the prospect of advocating, even as an emergency measure, some other category of personnel who, with a brief period of training, might be equipped to serve as an aide to a psychiatrist, a physician, a psychologist, a social worker or a nurse, in mental health care.

The Committee concluded that the needs might be better met by developing and extending the previously mentioned vocational programs for social work aides, certified nursing assistants, and a baccalaureate program for psychometrician or psychological technician.

It is noteworthy, in this connection, that in Saskatchewan a resolution was passed (1966) by the Provincial Council of the Psychiatric Nurses organization to abandon the identity of "nurse" and to become legally recognized as "mental health workers". The resolution read:-

> "1. To divorce ourselves from and to no longer identify ourselves with the general nurse and their traditions.
>
> 2. To institute legal action to have our name changed to "MENTAL HEALTH WORKERS" under the Act.
>
> 3. Establish a new curriculum under a new philosophy to encompass the training of Mental Health Workers in both a hospital based situation and community service.

Your Council Members consider this situation emergent and are acting accordingly."

Mental Health Volunteer

There is one other category of personnel, non-professional and untrained, who in Alberta, as in other provinces, has played a substantial role in certain aspects of mental health care. This is the volunteer. The volunteer service program has been organized by the Canadian Mental Health Association. A good deal of useful enthusiasm has been engendered by this program among volunteers. The mental hospital staffs have come to appreciate the contribution that volunteers make. At the present time there are 400 volunteers serving in rotation at the Alberta Hospital, Edmonton. They serve a useful function in simply providing a stimulating companionship to long-stay patients in the mental institutions, not requiring specific training or experience. They organize programs of recreation. The annual summer camp at the lakeshore for mental hospital patients is organized almost entirely by volunteers. They also play a role in helping individuals in social and occupational re-adjustment after discharge from the hospital. In the day care program for autistic children at the Provincial Guidance Clinic, Calgary, mothers of some of the children usefully serve as volunteer "child care workers."

Because the valuable contribution to the manpower shortage of the volunteer has been amply demonstrated, and because the volunteer serves a unique role toward the patient, it is recommended that this program through C.M.H.A. be given every encouragement and support by the Department of Health.[1]

CO-ORDINATION OF INTERDISCIPLINARY EDUCATIONAL PROGRAMS

With the realization of the importance of the members of each of the professional personnel fulfilling his optimum role in mental health care the development of team activity is essential. It would be of the utmost importance, then, that effective communication be maintained between the different members of the team. To this end consideration should be given by medical schools to the program of joint training for health related personnel, which is being developed at the University of British Columbia under the leadership of Dean McCreary (1968). A health training facility is being set up for the joint teaching of students in medicine, nursing, social work, clinical psychology and other health-related personnel.

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[1] Another "volunteer" program, which merits strong support, is that of the Alberta Service Corps. The young people, who worked in the mental hospitals last summer, brought a bright, enthusiastic and stimulating force for change to those institutions and their patients. The Departments of Youth and Health should repeat and extend the program in future years. Some additional instruction for the participants regarding how they might contribute to a greater extent is required. WRNB.

The Effect on Manpower of Government Policy

For the recruitment of the much needed professional personnel for mental health care the matter of incentive is paramount. Financial reward is only one aspect of the matter. A conducive professional and occupational "climate" is of great importance.

It should be recognized that, with the present attitude and style of operation, professional personnel will not be sufficiently attracted to the provincial institutions. Cognizance should be taken of the significance of the persistent drain of medical personnel away from government services to the independent style of practice typified in the private practice of medicine. Service in the mental hospitals and outpatient services of the present guidance clinics would become much more attractive to professional personnel if they could care for patients there in the same style as in general hospitals and private practice. This would be achieved if mental hospitals were put on the same administrative basis as general hospitals, under the provisions of the Hospital Insurance Act, and where the prepaid medical insurance plans could be in effect. It would be much more conducive to psychologists and social workers if their services were covered under the Alberta Health Plan and the associated prepaid medical insurance plans.

Yet with this, there would always remain certain functions to be performed by physicians, psychiatrists, psychologists, and social workers, that could best be remunerated on salary rather than fee-for-service.

The organization and employment of the Provincial Guidance Clinics are in need of review. A study carried out recently by the University of Alberta, Department of Educational Psychology, surveying the attitude of social workers, psychologists and physicians, revealed an extremely low rating of the usefulness of the clinics under their present mode of operation. With respect to manpower, there is, then, not only the problem of low incentive but also that of optimum utilization of professional staff. The indications are that such personnel as are employed in the guidance clinics might be better utilized in rather different functions. Particular reference is made here to travelling clinics.

The organization of community mental health services with psychiatrically trained public health nurses as the key personnel remains as virtually a new undertaking for Alberta, one which is likely to offer high incentive for nurses. It is envisaged that this could best be done through the reorganized regional public health service, (embodying nine health regions and, in addition, the two urban areas of Edmonton and Calgary).

As a first essential step to deal as a whole with the pressing manpower problem the Minister of Health should immediately appoint and make regular use of an Advisory Committee on Manpower for Mental Health. The members should be representative of the several mental health related professional organizations each nominated by their respective organization.[1]

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[1] The committee should be linked through some common membership (e.g. its chairman) with the Health Services Advisory Council proposed in Chapter 4 (Organization and Administration). WRNB

RECOMMENDATIONS

Psychiatrist

1. In order to attract psychiatrists in urban areas to serve in the mental hospitals the administration of those hospitals should be so changed as to enable the psychiatrists to practice in the same style as is the tradition in the community and in the general hospitals.

2. For the Alberta Hospital, Ponoka, to be made more attractive to more psychiatrists, its function should change to that of a community hospital, a hub from which mental health services are distributed widely throughout the surrounding region.

3. Influence should be brought to bear through the Alberta Psychiatric Association and the University Departments of Psychiatry to change the role of psychiatrists traditionally practising privately as therapist-practitioners to that of consultant to other professional personnel, particularly to family physicians.

4. For purposes of recruitment the Government should establish a new organization responsible for a vigorous publicity campaign, such as a Department of Development and Human Relations.[1]

5. Care should be taken by the College of Physicians and Surgeons of Alberta to eliminate unnecessary restrictions on eligibility and to develop good public relations towards psychiatrists and prospective trainees from elsewhere enquiring about the opportunities in Alberta.

6. In so far as the Provincial Mental Hospitals and Guidance Clinics need to engage psychiatrists on salary, the salary schedule will have to be greatly increased to be competitive with psychiatrists' income from private practice.

7. Most of the psychiatric staff requirements of the mental hospitals and guidance clinics should be met by engaging psychiatrists on the basis of fee-for-service as prevails in the practice of medicine generally.

8. The Provincial Mental Hospitals and Guidance Clinics should be prepared to establish as many positions for psychiatrists in training as are enrolled in the graduate training program in the University of Alberta.

9. To divert potential manpower into the specialty of psychiatry the medical schools should ensure that undergraduate medical students are properly oriented towards the relative needs of the community for psychiatrists, and the Department of Psychiatry should intensify its efforts to encourage graduating students towards the specialty practice.

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[1] Termed simply "Personnel Development" in Chapter 4 on Organization and Administration. WRNB

Recommendations cont'd.

10. Attractive professional training grants in adequate numbers from whatever source, or any alternative means of extra financial inducement, should be made to medical students preparing for their specialist qualifications in psychiatry.

11. The graduate training programs in psychiatry should be modified to ensure that the trainees are prepared for the changing role of psychiatrist towards that of consultant to the family physician and various professional personnel rather than simply that of therapist-practitioner.

Family Physician

1. As a means of increasing incentives for family practice with its important bearing on mental health care the College of Family Practice in Alberta should be given all possible encouragement and support in its endeavours to improve the image and enhance the status of the family physician.

2. The medical schools of Alberta should undertake the responsibility of making clear to medical students the particular importance of family practice.

3. All necessary encouragement and support should be given to teaching hospitals in establishing administrative departments of family practice and to faculties of medicine in establishing Chairs of Family Practice.

4. Special professorial training grants should be offered to medical graduates undertaking postgraduate study to qualify for the teaching of family practice.

5. The university faculties of medicine should be urged to ensure that in the training of general physicians they are given a firm grounding in the basic behavioural sciences, psychodynamics and psycho-social medicine.

6. The university faculties of medicine should immediately plan to offer postgraduate courses in psychological medicine for practising physicians, and for this purpose they should be offered special grants.

7. Grants-in-aid should be offered to physicians taking postgraduate courses in psychological medicine.

8. The university faculties of medicine should be urged to offer to family physicians substantial programs of continuing medical education in psychiatric care.

Psychologist[1]

1. All necessary encouragement and support by the Government should be offered to the departments of psychology at Alberta universities to introduce or extend programs for the preparation of psychologists to practice in the mental health field.

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[1] These recommendations are in general agreement with the submission from the Psychologists' Association of Alberta which is published in Vol. II.

Recommendations cont'd.

2. The universities should be encouraged to offer training programs in psychology as preparation for the professional role of psychometricians or psychological technicians at the baccalaureate level.

3. Levels of remuneration for psychologists serving in the mental health facilities of the Provincial Government should be raised to be competitive with those offered in academic settings and private agencies.

4. More attractive professional training grants should be made available for university graduates specializing in clinical psychology.

5. A position for a senior psychologist at the doctoral level should be provided in each of the Provincial mental hospitals and major guidance clinics for supervisory and educational purposes.

6. A post of Advisor in Psychology to the Department of Health should be created and filled by a senior psychologist with both clinical and relevant research experience.

7. Amendment should be made in the "Psychologists Act" to make a doctoral degree in psychology the minimum legal requirement for a psychologist functioning independently in private practice.

8. The university faculties of education, through their counsellor education programs, should provide more ample basic courses and "continuing education" courses for school counsellors.

9. The universities should intensify their training programs for school psychologists.

10. School Boards should make provision for employing a greatly increased number of school psychologists.

11. The grant and subsidy policy of the Department of Education should be broadened so that the services of psychologists would be extended to all schools in the Province and should not be confined to those psychologists who hold a teacher's certificate.

Social Worker

1. The opportunities for professional social workers should be widely and intensively publicized through the Public Information Service to high school graduates and to baccalaureate university graduates.

2. More conducive professional training grants should be offered to university candidates proceeding towards their social work qualification.

3. The establishment for social workers at the two Provincial Mental Hospitals should be, as a first step, increased to at

least 12 each, to be deployed predominantly in the follow-up care of patients discharged from the hospitals.

4. Vocational training programs for social work aides, child care workers and welfare workers should be encouraged and supported.

5. Wherever social work aides and welfare workers are employed in mental health services they should be under the direct supervision of qualified social workers.

6. A social worker consultant of high qualifications and wide experience should be appointed to the Department of Health to organize a recruitment program for social workers and social work aides to make for the optimum utilization of their skills.

Nurse[1]

1. A post-basic program in psychiatric nursing should be offered by the School of Nursing at the University of Alberta.

2. The University of Alberta, in conjunction with universities in other western provinces, should develop an advanced psychiatric nursing program at the Master's level.

3. Special inducements should be offered through attractive grants and bursaries for registered nurses taking postgraduate courses in psychiatric nursing either in Alberta or elsewhere.

4. The present 3-year psychiatric nursing programs offered at the two Provincial Mental Hospitals should be condensed to two years. Similarly, the present 4-year combined program at the Alberta Hospital, Ponoka, should be shortened to three years.

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[1] Additional recommendations, which should be considered by the Government, originated outside this study of manpower, education and training.

1. The A.A.R.N. recommends that all nursing education come under the direction of the Department of Education. This recommendation is strongly supported by nurses' groups within the mental health service and has my support, too.
2. Nurses in mental hospitals are convinced that nursing service and nursing education must be the responsibilities of separate departments. This distinction is implied in Recommendation #6. It is now specifically recommended that education departments separate from service, be established at Ponoka and Oliver and be headed by Directors of Nursing Education.
3. More adequate educational facilities (staff, library, classrooms, offices, change rooms, teaching aids) should be provided in the mental hospitals. Present inadequacies are of great concern to nursing staffs.
4. The Psychiatric Nurses' Association of Alberta recommends that new educational programs for nurses, both basic and advanced, be designed and developed to meet the needs of nurses in the mental health field. I support this recommendation, too. WRNB

Recommendations cont'd.

5. Supplementary courses in nursing should be provided which would enable the registered psychiatric nurse to meet the requirements for the R.N. qualification.

6. The courses of training for ancillary nursing personnel should come under the jurisdiction of a director of nursing education appointed to designated hospitals and institutions.

7. The mental hospitals should organize continuing education programs for nursing and ancillary nursing staff.

8. The training program for "Mental Deficiency Graduate Nurses" at the Provincial School Hospital should come under the jurisdiction of a central educational body and eventually be transposed into a vocational program for wider recognition.

9. An Alberta Council of Nursing should be set up as a central planning body consisting of representatives of education, hospitals and other health services, and the public. The Council should be empowered under charter for the licencing of all categories of nursing personnel. It should be responsible for the co-ordination of all educational programs for nursing personnel.

10. Salary scales for nursing personnel should be reviewed. Recognition of the extra skills of the qualified psychiatric nurse should be respected in the salary scale.

11. A highly qualified psychiatric nursing consultant should be appointed to the Department of Health and advisors made available to the mental institutions with a view to ensuring that qualified nurses and ancillary nursing personnel under their supervision are deployed appropriately to their qualifications.

12. Public health nurses, given adequate training in mental health, and psychiatric nurses, given adequate training in community nursing, should be attached to Regional Public Health Units for home visitation and clinic service for mental health.

13. A research and planning council should be set up to develop multi-disciplinary research in nursing practice for mental health.

Other Therapists

1. The establishment for occupational therapists at each of the mental hospitals should be increased as rapidly as qualified occupational therapists become available.

2. The training program for occupational and recreational therapists at the University of Alberta School of Rehabilitation Medicine should be enriched by the inclusion of much more practical experience in dealing with mentally or emotionally disordered patients.

3. Those responsible for any new mental health program should also investigate and take action regarding the need for therapists not mentioned in this Chapter, e.g., speech therapists.

Other Mental Health Personnel

1. Because volunteers have made a valuable contribution to the care of the mentally ill through the mental hospitals, all possible encouragement should be given to the Canadian Mental Health Association Volunteer Program by the Government.[1]

Government Policy

1. To create a climate more conducive to professional personnel the Provincial mental hospitals and Guidance Clinics should be administered on the same basis and the same style as general hospitals and medical clinics and come under the provisions of the Hospital Insurance Act and prepaid medical insurance plans.

2. To encourage the participation of professional personnel in mental health, the services of psychologists, nurses and social workers should be covered under the Alberta Health Plan and the associated prepaid medical insurance plans.

3. An advisory committee on manpower for mental health comprised of representatives of the several mental health-related professional organizations should be appointed and used by the Minister of Health.[2]

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[1] I would add that the Alberta Service Corps should be enable to extend its fine beginning in the mental health field through the summer employment of some of its members at mental hospitals. WRNB.

[2] As noted earlier, this proposed committee should be linked with the Health Services Advisory Council (Chapter 5). WRNB.

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CHAPTER 7

PUPIL PERSONNEL SERVICES IN ALBERTA SCHOOLS[1]

Committee

Chairman:	Dr. John G. Paterson, Ed. D.	Director of Counselling Centre Faculty of Education University of Alberta
Members:	P.W.R. Holt, M.Ed.	Director of Special Education Edmonton Public School Board
	Mrs. Gayle James, M.S.W.	Social Worker - Education Clinic Edmonton Public School Board
	D.A. Kinley, M.Ed.	School Psychologist Edmonton Public School Board
	Dr. Riyad Ousta, Ph.D.	Director of Guidance and Special Education, County of Red Deer
	Dr. Harvey Zingle, Ph.D.	Director of Counsellor Education Program, University of Alberta

INTRODUCTION

The committee members saw this task as one of description and definition as well as recommendation. It is believed that pupil personnel services in schools are essential to any provincial system which attempts to provide mental health services to communities, large and small. The recommendations have been determined by perceived needs of children and apply to several government departments, in some cases local, as well as provincial.

Mentally Healthy Children (Adapted from Laycock, 1960)

a. They feel comfortable about themselves.
b. They feel right about other people.
c. They are able to meet the demands of life.

Characteristics of Maladjusted Children (From Magary, 1967)

Maladjustment is defined as the marked presence of one or more of the following characteristics over a period of time.

a. An inability to learn that cannot be solely explained by intellectual, sensory, or general health factors.
b. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
c. Inappropriate types of behavior or feelings under normal conditions.
d. A general pervasive mood of unhappiness or depression.

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[1] This Chapter is a shortened version of a report of the Study Group on Personnel Services in Alberta Schools. WRNB

e. A tendency to develop physical symptoms such as speech problems, pains, or fears associated with personal or school problems.

From these definitions it is possible to look at needs of children, and the services provided by schools to meet those needs.

NEEDS OF SCHOOL CHILDREN

The Importance of the School

Statistics on emotional problems of children, delinquency, marital discord and other social and personal problems are favoured topics of the press, pulpit and the living room. These public concerns are reflected in the schools, as they are the "second line of defence" against maladjustment, second only to the home.

In the formative years of later childhood, adolescence and youth, classrooms serve as arenas in which skills and powers are developed and organized. School influences on personal development and mental health cannot be over-emphasized. Schools cannot avoid playing a part in the formation of personality and values. Children are influenced by who their teachers are, what they do, by beliefs and behavior of their classmates and by the content and methods of instruction. Mental health and academic outcomes of education are not matters of alternate choice. Intellect and emotion are integral aspects of children, and the fullest development of either depends on the development of the other. Anxiety and maladjustment block and inhibit natural capacity, reducing both the learning level and the learning rate.

One basic assumption of this committee is that if a child with a developing emotional disorder can be detected early, he can be helped most economically and effectively. It is noted that only two institutions in our society, the family and the school, have contact with all children. Hence, the teacher is usally the first person trained in child development to come into contact with children who have developing emotional problems.

Need fulfillment is a requisite for a sound mental life for children. In this respect the school is concerned with the whole range of needs of children, but primarily with those that relate to intellectual, social and emotional development. In Education and Early Childhood (1956), the California State Department of Education presents an excellent summary of some of the needs of children where the school can make a contribution.

1. Affection, Friendship: The teacher must be a friend of children, abd the school must be a friendly place where the making of interesting friends is an objective.

2. Self-Respect: Suitable programs allowing success for each student are mandatory.

3. Freedom: The school should take students into partnership in planning school experiences and should respect their contributions.

4. Respect for Authority: Children turn naturally to their teacher and respect him when they are convinced of his interest, justice, courtesy, wisdom and competence.

5. Challenge: Curiosity should be stimulated and intellectual challenge fostered.

6. Security: Since school is the principal occupation of children, it must take a responsible role in fostering a sense of security.

7. Understanding of Nature: The school should help children to understand natural phenomena, e.g., birth, growth, decay.

8. Creativity: The school should enable children to express themselves creatively and aesthetically.

9. Values, Appreciation: Students need to feel wanted, valued, and appreciated as persons in the school setting.

Our Social Context

As a natural evolution our society keeps changing and shifting from simplicity and disorder toward civilization and complexity. This movement toward a more highly developed social order is purposeful in that it provides stability, security, and predictability not possible in a sociopathic state. Maturation of our society means that there are a more complex number of skills and values to be transmitted to children if they are to be "properly" enculturated or socialized. A "proper" job of cultural transmission is critical for the mental health of children.

A further characteristic of our maturing society is the proliferation of agencies of socialization. A list of contemporary influences on the learning and development of children would assuredly include the family, the peer group, the church, the residential community, the business community, the physical environment, the mass media, the school, and various other public and private institutions. Children are subject to unique and varied influences from these sources. Values imparted by various agencies are often contradictory and purposefully so. To cite but one example: the home, school and church strive to teach children honesty, while the business community and the mass media often provide a model of deliberate deception.

T.V. may be cited as a specific example of an agency of socialization which is not put to constructive use although its potential for the enculturation of children is phenomenal. McLuhan (1966) has pointed out that T.V. has changed children's sensory lives and has created a taste for all experience in depth. So the traditional means of classroom instruction has become both dull and dated. Over a given year, children spend as much time watching T.V. as they do in school, (Chandler, 1960, *et al*.) yet private T.V. interests appear to assume only the responsibility for molding children into discriminating consumers, and educational television is forced to use V.H.F.

While schools attempt to motivate children, who are captivated by television, they also find their scope and responsibilities are increasing. Some feature of the newer demands on the school follow:

1. As indicated above, other agencies of enculturation are providing teaching which is inconsistent with that expected of the school. As well, certain media and institutions are not being used to advantage.

2. Closely related to #1 are the changing influences of the home and the church, reflected in pressure for inclusion of such topics as sex-education in the curriculum.

3. There is a continuing trend toward a longer period of formal education and a higher level of academic achievement. Porter (1965) reports the percentage of youth in Canada aged 15 to 19 still in school rose from 35.5% in 1941 to 58.5% in 1961. In the 20 to 24 age group, the percentage still in the school population rose from 3.7% to 8% over the corresponding period of time.

4. The explosion of knowledge has meant the introduction of many new school subjects. It has also required that students be confronted with more sophisticated knowledge at lower grades.

5. The school population is becoming more heterogenous. Factors contributing to increased diversity of the student population include (a) changes in ages of compulsory school attendance, (b) medical technology, which has lowered infantile mortality but raised the percentage of children with physical abnormalities, e.f., neurological impairments, (c) the trend toward provision for all types of exceptional children under the public schools' jurisdiction. Public schools are in fact one of the very few institutions providing for children who must, almost without exception, accommodate all applicants.

As the scope of the schools' influence has been extended, decisions concerning educational purposes, aspirations, wants and desires, have become more complicated. Questions about which values should be served by public school systems are difficult and pressures are exerted from a variety of sources. Value judgments are troublesome for educators because there is no universal criterion. Broudy (1967) outlines one value dilemma of educators as follows:

> "We are to redeem the disadvantages, but not presumably by imposing middle class values and demands upon them. But if one asks in what way the disadvantaged are disadvantaged, we are told they lack the means to achieve what seems suspiciously like middle class values." (Broudy, 1967, p. 115).

Value judgments by the school are made even more complex by the questioning of traditional values.

To summarize - within the social context described above, the schools of today find themselves with increasing responsibilities, competing in authority with other institutions, accommodating a more heterogeneous school population for a longer period of time, and confronted by a perplexing set of value dilemmas.

DEVELOPMENT OF PUPIL PERSONNEL SERVICES

Definition

Based on the belief in the importance of each pupil, the goals of education in Alberta are to provide opportunities for each student to gain a sense of his own value that will help him to realize his uniqueness and achieve his responsible place in the community. Publicly supported programs of class instruction have long been accepted as a very important means of developing a sense of self-realization and community responsibility. The notion that the teacher cannot provide or possess all of the talent necessary for optimum learning is not as readily accepted.

Pupil personnel services may be defined as those professional services other than classroom instruction and school administration, which are offered by the school to help pupils attain their maximum personal development, and further, to facilitate the efforts of parents and teachers in the guiding and teaching-learning process (Lowe, 1962). These services are for all children at all levels of ability, achievement and adjustment, and as such are not limited to remedial, disadvantaged, and crisis-orientated situations.

Pupil personnel services, then, are supportive of classroom functions and not a substitute for them. They are often performed by school counsellors, remedial specialists, speech and hearing specialists, school psychologists, school social workers, health specialists and research personnel. Special education for exceptional children often falls within their scope.

In Alberta almost all pupil personnel workers, except health specialists, are dually qualified, first as teachers, secondly as specialists within their discipline. In general, they have no teaching responsibilities but educational training and experience are deemed important for them to fulfill their supportive role to instruction.

Milestones in Pupil Personnel Services Development in Alberta.

1895 - An advertisement in a Calgary newspaper was placed by local school authorities "calling attention to the disastrous effects on school work in the senior classes of excessive indulgence in evening amusements, and in junior forms of truancy, and asking the cooperation of parents in removing this obstacle to progress in the schools." (Handbook, Division of Special Educational Services, Calgary Public School Board).

1919 - Calgary Public School System opened its first special class for "retarded" children.

1929 - Calgary Public School System opened its first "sight saving" class.

1936 - Department of Education regrouped grades, as follows:
Grade 1 to VI - Elementary Division
Grade VII to IX - Junior High School Division
Grade X to XII - Senior High School Division

1938 - Guidance became an actual subject for study in Calgary Public High Schools with the introduction of a course on Vocations and Guidance.

1941 - A course in Guidance was included in the Edmonton Summer School Program for teachers.

1945 - Mr. H.E. Panabaker became the first Supervisor of Guidance in Calgary Public Schools and in the Province.

1947 - The first counsellor was appointed at Lethbridge Collegiate Institute.

1947 - Mr. A.A. Aldridge became the first Supervisor of Guidance with the Department of Education.

The Differential Aptitude Test, a test to diagnose intellectual strengths and weaknesses, and the Kuder Preference Record, an occupational choice scale, were introduced into Alberta Schools.

1947 - Red Deer Composite High School opened with a part-time guidance counsellor.

1949 - A Cumulative Record Card, designed to make available pertinent school records on each student for purposes of guidance was introduced into Alberta Schools.

1951 - First "Career Day" sponsored by the Department of Education was held at Wetaskiwin.

An Educational Clinic at the Faculty of Education, University of Alberta was established to train teachers in the diagnosis and solution of learning problems. Its focus was individual diagnostic testing.

Edmonton Public School System appointed their first "Visiting Teacher". She was the first pupil personnel worker assigned to Central Office. Teacher-Counsellors were already on the scene in many Junior and Senior High Schools in Edmonton. There were 140 such personnel in Calgary Public School System.

1954 - Six opportunity classes were in operation in each of the Edmonton and Calgary Public School Systems. The classes in Calgary were for children with hearing and visual handicaps as well as for slow learners.

1955 - Thirty-nine persons attended the Second Annual Provincial Counsellors' Conference at Red Deer. In 1961 this organization became known as the Guidance Council under the A.T.A.

1955 - A number of rural school divisions appointed Supervisors of
1956   Guidance, including Cardston, Vermilion, and High Prairie.

1957 - Supervisor of Guidance and Special Educational Services described the guidance program in Calgary Public Schools to his Board as follows:

> "Individual appraisal through the use of tests of ability, interest, and aptitudes, individual counselling, referrals to the National Employment Service for the placement of students wishing to start work, regular evaluation of the effectiveness of the guidance program, and careful research studies for further improvement."

1960 - The Edmonton Public School Board hired its sixth Central Office pupil personnel worker.

1961 - A supervisor of Guidance was appointed in the Public Schools of the City of Medicine Hat.

1962 - An Education Clinic in the Department of Educational Psychology, University of Alberta at Calgary, similar to that in the University of Alberta, Edmonton, was set up.

1963 - The new Faculty of Education Building at U. of A. opened, with progressive facilities for training school counsellors, school psychologists, and reading and language specialists.

1964 - Administrative structure for Pupil Personnel Services organized in Edmonton Public Schools.

1965 - Four full time elementary school counsellors were appointed to Edmonton Public Schools.

1965 - McMurray Vocational School, a training centre for Indian and Metis adolescents and adults, opened.

1966 - A Learning Assistance Centre was opened by Calgary Public School Board. Its purpose is clinical diagnosis and remedial therapy for each academically retarded child referred to it.

1967 - An Education Clinic staffed by a full time teacher, a psychologist-director, two psychologists, two remedial specialists, a speech clinician, a social worker and consulting pediatrician began operation in the Edmonton Public School System. The function of this Clinic is quite similar to the Learning Assistance Centre in Calgary.

1967 - The new Faculty of Education Building at the University of Calgary opened. It contains facilities for the training of school psychologists, school counsellors and reading and language specialists. Among these facilities is the Psychoeducational Clinic of the Department of Educational Psychology.

1968 - Edmonton Public and Separate Schools sponsored a four-day Career Fair with 80 exhibits in Edmonton's Sportex Building. More than 18,000 high school students took part.

Calgary Roman Catholic Separate High Schools hope to reach a counsellor-pupil ratio of 1/300 in September of this year.

Pupil Personnel Workers and Clientele

Counsellors

The school counsellor is at the frontline of pupil personnel services. He is the one member who works with all children, those with questions as well as those with serious problems.

In the school system of the Province of Alberta it is difficult to decide which staff members should be labelled counsellors, and equally so, to give a clear picture of just what guidance and counselling activity is undertaken. A few statistics from a Canada Manpower study published in 1967 (Volume 1), Career Decisions of Canadian Youth, should provide, however, some illumination. Twenty-seven per cent of the teaching staff of Alberta schools is involved in guidance work of some kind. Much of the work is group guidance instruction, although individual counselling is done. Fifty-three per cent of those engaged in guidance work in Alberta spend less than one hour per week with this work. Eighty-one per cent of those engaged in guidance work in Alberta have no certificate, diploma or degree in guidance.[1] Ninety per cent of Alberta school principals engage in guidance work, and of these ninety-one per cent have no certificate, diploma or degree in guidance work.

According to the report, fifty-nine per cent of Alberta teachers and counsellors think that the number of guidance personnel in their schools is insufficient, and eighty-two per cent of the principals agree. Fifty-seven per cent of Alberta principals think that space devoted to guidance in their schools is inadequate, and seventy-four per cent of them think their facilities and equipment available for guidance are inadequate.

Students served by guidance in Alberta schools are mainly at the junior and senior high school levels, although a start has been made in extending services to elementary schools.

Guidance and counselling work may be characterized as educational, vocational, and personal; and it is required because youth cannot benefit maximally from their education unless they receive group guidance, and sometimes individual counselling, to supplement the schools' academic offerings.

Special Class Teachers

The teachers of classes for exceptional children in public schools have, historically, been drawn from the teachers of regular classes and have been chosen for their personal qualifications and their teaching skill. Specialist training followed, but has lagged behind the establishment of special classes. "Cadet training", a combination of formal instruction and practice teaching offered by institutions in the early 1900's provided training for teachers of the mentally retarded, the blind and the deaf. In more recent years colleges and universities have developed programs for the preparation of teachers to work with various types of exceptional children. Alberta has recently developed a program to prepare teachers to work with the educable mentally retarded and the emotionally disturbed. This enables elementary teachers to gain a "major" in special education at the undergraduate level.

Special Education Clients

Children requiring the services of Special Education are defined by Dunn (1963) as those:

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[1] The situation is not as bad in the two large city systems but the Province as a whole is our concern. WRNB.

> "(1) who differ from the average to such a degree in physical or psychological characteristics (2) that school programs designed for the majority of children do not afford them the opportunity for all round adjustment and optimum progress, (3) and who therefore need either special instruction or in some cases special ancillary services, or both, to achieve a level commensurate with their respective abilities."

He estimates that "approximately 8 per cent of the school age population are now so exceptional in one or more areas as to need one or more special education services." The following table presented by Dunn indicates the breakdown of this group as estimated by the U.S. Office of Education and the Dominion of Canada Bureau of Statistics.

AREAS OF EXCEPTIONALITY[a]	PERCENTAGE ESTIMATED	
	U.S.O.E.[b]	D.C.B.S.[c]
Intellectually limited	2.3	2.0
Educable mentally retarded	(2.0)	
Trainable mentally retarded	(0.3)	
Intellectually superior (gifted)	2.0	2.0
Disturbed and maladjusted	2.0	2.0
Emotionally disturbed		
Socially maladjusted		
Speech impaired	3.5	2.10
Hearing impaired	0.6	0.54
Hard of Hearing	(0.5)	
Deaf	(0.1)	
Visually impaired	0.09	0.13
Partially seeing	(0.06)	
Blind	(0.03)	
Nonsensory physically impaired	2.0	0.47
Crippled	(1.0)	(0.1)
Chronic health problems	(1.0)	(0.37)

a - Pupils with multiple special education needs counted more than once.
b - From Mackie, Romaine P., Personal communication, 1962.
c - From the Dominion of Canada Bureau of Statistics, Statistics of Special Education for Exceptional Children, 1954-1959. Ottawa: Queen's Printer 1959.

Application of these figures to an urban Alberta centre such as Edmonton with a school age population of 70,000 would indicate a need for special education services of some kind for 5,600 students, far in excess of the approximately 1,200 students now in special classes.

Increased attention in special education is now being assigned to children with learning disabilities other than those having a distinctly physical basis. These include children with various perceptual handicaps and those with varying degrees of neurological disorders such as cerebral palsy.[1]

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[1] A brief from the Calgary Cerebral Palsy Association is published in Volume II. In addition, a later chapter will be concerned with intellectually and neurologically handicapped children. WRNB.

In the past these children have been variously classified as "educable-retarded", emotionally disturbed, or neurologically impaired. Today, attention is given to specific teaching techniques aimed at compensating for the particular handicap.

Other Specialists in Pupil Personnel Services

Traditionally, pupil personnel services have comprised these categories:

Guidance Services
Health Services
Psychological Services
School Social Work Services
School Attendance Services

Two other specialties, which are gaining increasing recognition in recent years should be added: Remedial Learning and Speech Therapy.

Different combinations of specialists have been employed in Alberta to help meet needs of children in schools. Services have more meaning than labels in this context and the boundaries of responsibility of the professional personnel named above should not be fixed rigidly.

Most frequently, teacher training in addition to professional training in a discipline, (e.g. a graduate degree in social work or in psychology) has been a prerequisite to employment in a school setting.[1] There have been varying opinions as to the desirability of teacher training plus professional training in the behavioral sciences, and recently the two major public school boards (Edmonton/Calgary) have been experimenting with hiring social workers, and in one instance a psychologist, who lack teacher training. In two such instances it is of interest to note that considerable financial support for this arrangement has been provided through Preventive Social Services, Government of Alberta.

Guidance Counsellors and Special Class Teachers were discussed earlier. Other categories will be presented now.

Psychological Services

School Psychologists usually have training at the Master's level,[2] either in Education or in Arts, with sufficient other courses to provide them with a teaching certificate. They are often the chief liaison between the school and social agencies, parents, and other interested public groups. They may head a section of professionals, who have responsibility for students in a particular geographical area, and in that role co-ordinate efforts of others to help students. They are usually responsible for individual testing to help determine special class placement for a student, recognition and diagnosis of problems that may require referral for treatment, and they act as an interpretive agent between the school and any outside social agency. They are readily available consultants to the classroom teacher, interpreting the behavior of students and offering suggestions for management.

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[1] The Study Group on Manpower, Education and Training proposed a broadening of policy to permit the employment of psychologists, without teacher's certificates, in the school system. I suggest that the possibility should be given serious consideration with the objective of making full use of all appropriate resources. WRNB

[2] If they have less, they are not "psychologists", according to the legal definition in Alberta. WRNB

School Social Work Services

School Social Workers, who ideally possess a minimum of a Master's degree from an accredited social work school, seem to be employed only in the larger urban centres. Not infrequently they are solely responsible for school attendance services and, because in large areas this is an enormous task, there is often little time left for casework or group work services. The Edmonton and Calgary School Boards employ trained social workers but the smaller areas, including Lethbridge and Medicine Hat,do not have a single trained social worker on their staff, and either rely on trained social workers employed by other agencies (e.g. at Medicine Hat it is the Family Service Bureau), or do without. This illustrates a recurring deficiency. The large urban areas, Calgary and Edmonton, have barely sufficient numbers of professional personnel. In the small urban areas, including Medicine Hat and Lethbridge, they are almost non-existent. Rural areas, towns and villages have little chance of employing any professional pupil personnel workers.

School Attendance Services

The trained social workers, if any, are usually found in this service. Their focus is short term counselling, with referral to and consultation with other social agencies if a problem has to be handled over a longer period of time. The attendance department workers, because they vary in training throughout this Province, often merely support the schools' authority and do not necessarily feel a responsibility for the wider aims of mental health. Their clientele includes all of those children who are inexcusably absent from school for any period of time. While both the Edmonton and Calgary Public School Boards and Separate School Boards have a full-time attendance department, the attendance officers at Lethbridge and Medicine Hat are part-time non-professionals.

Remedial Specialists, Remedial Reading Specialists

Ideally, remedial specialists possess a Master's degree in education and experience as teachers. In some areas their work is exclusively remedial; in others, primarily diagnosis and prescriptive teaching. New discoveries made by educators, paediatricians, neurologists and child guidance workers have made their work more important and productive. From 10% to 20% of the school population requires remedial assistance with problems of reading and comprehension.

Speech Therapy, Speech and Hearing Clinicians or Speech Pathologists

Speech therapists ideally possess a Master's degree in Speech Pathology and Audiology but there are few speech therapists in Alberta schools with this degree of qualification. Few speech therapists are available, even in Edmonton and Calgary, so their role is confined to diagnosis and short-term treatment.

The only Canadian universities training speech therapists are McGill and the University of Toronto. (The University of Alberta hopes to begin in 1969). The implication is that Alberta's working conditions, salaries, and training grants probably have to be more than competitive to ensure adequate numbers of personnel.

School Health Services

School nurses are made available through the Department of Health on a regular basis to maintain the health of school children, and to prevent disease in the school population. The school nurse may make home visits, is frequently in contact with the child's parents and is, therefore, aware of his home environment. As a group, they deal with the whole school population so they have a major role to play in the early discovery of mental health problems. In cooperation with the school counsellor they constitute an effective force for maintaining and enhancing a child's development at school. However, in the large urban areas, it would appear that the school nurse and the school counsellor are frequently not working in cooperation with one another, to the detriment of the total well-being of the children involved. This trend seems to be much less noticeable in rural areas, but it is taking on increasing significance in city schools.

The Alberta Picture: Organization and Services Available

Pupil personnel services provided by school systems in Alberta will be discussed in two major sections:

1. Large City Systems - Edmonton and Calgary.

2. Other Small Cities and Rural Areas.

1. Large City Systems

a. Calgary Public School System

The Division of Special Educational Services in the Calgary Public School System comprises seven departments.

Guidance Department
Visiting Teacher Department
Special Education Department
Learning Assistance Department
Psychological Services
Speech and Hearing Services
Attendance Department

i. Employs personnel in larger schools on counselling for three-quarters of their time.

ii. These teachers share responsibility for the atypical child with classroom teachers and are a link between home and school.

iii. Provides special curricula, instruction and facilities for exceptional children who are unable to progress in the normal classroom.

iv. Learning Assistance Department.

v. Psychological Services.

This department is essentially an educational clinic, concerned with diagnosis and remedial reading services for children with reading difficulties, and the upgrading of the public school reading program. This will be extended to other subjects, such as arithmetic and language.

Psychologists and psychometrists work primarily in the elementary schools with occasional referrals from junior and senior high schools, on diagnosis and evaluation, placement within the school, and individual assessment.

vi. Speech and Hearing Services.

Assess speech and hearing of school children.

vii. Attendance Department.

School attendance problems and related social difficulties.

In addition, an educational research element assists in the development of tests and the evaluation of educational programs.

b. Edmonton Public School System

i. Bureau of Child Study.

Services of the Bureau are designed to enable students to profit from educational opportunities. They are provided by the following specialist or facilities whose work has been discussed earlier:

School Psychologists
Social Workers
Remedial Specialists
Speech and Hearing Clinicians
Social Worker - Attendance Officer
Education Clinic--in Edmonton it deals with certain of the more difficult cases referred to the Bureau of Child Study. The staff includes the following full time personnel: Clinical Director, Observation Class Teacher, Clinical Psychologists, Remedial Specialists, Social Worker, Speech and Hearing Specialists, Secretary. Medical doctors are available for consultation.

ii. Counselling Services in Elementary, Junior and Senior High Schools.

iii. Special Education.

The Department of Special Education in Edmonton provides services or special classes for intellectually, physically and neurologically handicapped children. Other services include homebound services to pregnant girls, a detention centre, and special services to pupils suffering from serious emotional disorders.

2. Smaller Centres and Non-Urban Areas

Considerable changes in the quality and quantity of pupil personnel services have taken place recently outside the large cities. Within the last four years, the demands of home and school associations for improved and extensive guidance services have resulted in directors of pupil personnel services being hired for the first time.

It should perhaps be explained that these smaller centres through their Supervisor of Guidance or School Psychologist try to maintain a wide variety of services. One professionally trained person may be expected to perform the varied tasks of several specialists in a large city school system. Furthermore, few of the smaller centres and non-urban areas have an organized pupil personnel service. The organization varies from one school system to another. Certain areas, e.g. Red Deer County No. 23 or Mountainview, provide many of the pupil personnel services which are offered in the Edmonton or Calgary Public School Systems. However, other areas, like Rocky Mountain House or Wetaskiwin, appoint part-time school counsellors and have very little commitment to pupil personnel services. In short, few smaller centres and non-urban areas provide specialized professional help required by pupils in schools. Usually, such help is provided by the school psychologist or coordinator of pupil personnel services. Though the results of these programs are very encouraging, considerable expansion of the services is required before they can meet the need. School systems with little or no services delegate the special service tasks to a full-time teacher or a vice-principal.

CONTRIBUTIONS OF PUPIL PERSONNEL SERVICES TO MENTAL HEALTH

School Counselling

The school counsellor has been widely accepted in Alberta. With the public health nurse he represents a vital link between home and school. The extent to which counsellors promote mental health services beyond the school depends on the size of the community and other services available.

Despite serious limitations, school guidance and counselling services in Alberta schools are substantial, and comparable with other provinces (see the Canada Manpower report). In view of the needs of school children, however, the situation is far from acceptable. Contributions to the mental health of school children currently being made will now be mentioned and recommendations for improving the contribution will follow.

1. Group guidance contributions to the student include:

    a. Opportunity to discuss and grow in personal development, in terms of goal definition, self-assessment, decision-making and awareness of social responsibility.

b. Opportunity to learn about vocations and to develop realistic vocational aspirations.

c. Opportunity to learn about and discuss school courses and programs and post-school educational provisions.

2. Where trained counsellors are available, counselling contributions to the student include:

   a. Individual guidance.

   b. Help with personal, emotional problems.

   c. Assessment in terms of aptitude, vocational interest, academic ability, and other relevant areas.

   d. Professional referral services and close liaison with other community helping agencies.

3. Recommendations for improvements:

   a. More attention should be devoted to the promotion of elementary school counselling to reduce remedial work in higher grades.

   b. If counsellors are to perform their functions well, they must be enabled and encouraged by school administrations to increase their work with parents and with other community mental health personnel. They should be freed of tasks which can be performed by clerical personnel.

   c. More trained counsellors are urgently needed. Training bursaries are required to assist selected candidates.

Special Educational Facilities

Special educational services, described earlier, provide personnel, programs and facilities, which reduce many of the pressures and frustrations of the normal classroom for pupils who are not normal. The following types of classes have been established in Alberta and receive special support from the Department of Education.

1. Opportunity Classes

   These serve students whose ability falls in the I.Q. range of approximately 50 to 75. A total of 193 such classes are in operation in Alberta. Of these 74 are in rural or small urban centres.

2. Low Vision

   Six classes are in operation in Alberta for children whose vision is so low as to require special texts, intensified lighting and other special equipment. These are located in Edmonton (3) and Calgary (3). One Edmonton class is composed of students whose work is carried on in the regular classrooms. They also have the services of a travelling teacher who sees that they have all the necessary special help and equipment.

3. Speech and Hearing

Provisions are made in 12 classes (6 in Calgary, 6 in Edmonton) for hard-of-hearing children who are not able to function in the regular classroom. These classrooms are equipped with special amplifiers and are staffed by teachers specially trained for this work. Children are accepted into these classes at a younger age than usual to take advantage of the years when speech can be more readily developed.

4. Learning Disability

(Including emotionally disturbed and neurologically impaired.)

Forty-seven classes serve children with various learning disabilities and are known as Learning Disability, Adaptation, or Emotionally Disturbed Classes. In addition, a number of the hospital and institutional classes, mentioned later, serve this group.

5. Rehabilitation

One class is available in each of Edmonton and Calgary. An additional class will open in Edmonton in the fall of 1968. These are operated in cooperation with the Rehabilitation Associations.

6. Hospital Classes

Classes are provided in active treatment and convalescent hospitals to enable children to continue their education during prolonged periods of hospitalization. In addition, the Glenrose School Hospital, Edmonton, is provided with twenty-nine classroom teachers. Many of the children have never been able to attend regular schools due to severe physical handicaps. Five classes for the emotionally disturbed are included in the twenty-nine at the Glenrose.

7. Homebound

A home teaching service is provided for children who, because of physical or psychological handicaps, are not able to continue attendance at school. This group includes girls who become pregnant and later return to regular attendance.

8. Cerebral Palsy

Classes are provided for children in the Cerebral Palsy Clinic in Calgary (4), and as part of the Glenrose School Hospital program.

9. Provincial Diagnostic and Treatment Centre and Detention Centre

Ten classes are provided at this complex (Edmonton). It serves provincial government wards who are so disturbed that they cannot live in foster homes and attend regular community schools. Two of these classes serve children in detention awaiting court hearing or on remand.

Special Education and the Emotionally Disturbed Child

Esimates of the incidence of emotional disturbance in children vary widely and there is a serious lack of data on the subject in Alberta. A clear definition of the problem and the determination of possible solutions must await systematic research, which has been neglected here. In the meantime, however, an effort must be made to attend to the needs of those children, who have been identified as requiring special assistance, if they are to realize their potentialities.

Abrahamsen (1955) and Bower (1961) estimated that at least 10 per cent of the school age population were in need of psychiatric help. A report by Pate referred to by Dunn (1963) contended that almost all of the 10 per cent could be helped sufficiently through supportive services with only 0.5 per cent requiring intensive treatment in special classes. According to D.B.S. (1966) the number of Canadian pupils, actually enrolled in special classes for emotionally disturbed children, amounted to only 0.1 per cent of the school age population.

Alberta figures compiled by Kendall and Ballance (1967) suggest that the facilities and the staff fall far short of meeting the need. The numbers receiving special assistance appear to be less than the national average cited by D.B.S. (1966).

Facilities in Edmonton

These include:

1. Nineteen adaptation classes for mildly disturbed children; one special adaptation class which provides special features including individual cubicles for seriously disturbed children. (Both groups are identified by school psychologist and psychiatric consultation is often involved with the seriously disturbed).

2. The City School Board also provides teachers for the psychiatric units of the Royal Alexandra Hospital, the University Hospital and for classes from the emotionally disturbed wards of the provincial Glenrose Hospital.

3. In the fall of 1967 the Provincial Welfare Department opened a Diagnostic and Treatment Centre for emotionally disturbed government wards . This is a residential setting which provides facilities for approximately 55 children. Associated with it, and under the same educational administration is the City of Edmonton Detention Centre. Teaching and remedial staffs are provided by the City.

4. Homebound teacher service is provided for students who, on medical advice, are excluded from school or advised not to attend because of emotional problems.

Facilities in Calgary

1. Five classes are provided which serve emotionally disturbed children of normal intellectual ability who are two or more years educationally retarded. (Unlike the Edmonton System, Calgary deals

with other children with learning disabilities by having them attend regular classes and come into the clinic for daily remedial sessions.)

2. The William Roper Hull Home is a residential treatment centre for neglected and delinquent boys. Classes are operated at the Home by the Calgary Public School Board.

3. An adaptation class is operated in a regular Junior High School and serves as a transitional setting for boys from Roper Home who have improved behavior but are not yet ready to enter a regular class. Boys in the class are gradually integrated into regular classes in the school.

4. The Calgary Public School System operates a Psychiatric and Education Centre for severely disturbed children in close cooperation with the Alberta Guidance Clinic and with the assistance of the Junior League of Calgary which provides teaching assistants.

The importance of education in the treatment of emotionally disturbed children is being recognized to an increasing extent. The disturbed child needs to be as much like other children as his disability will allow. Furthermore, if he is to re-enter the normal population, he must be able to do so with as little disruption of his normal program as possible.

Because of their location and their necessary cooperation with other social agencies in the community, pupil personnel workers can contribute greatly to the mental health of the community. But many social agencies are concerned with the development of children. It is inevitable that the school and such helping agencies will frequently have an overlapping and simultaneous interest in the same child. Some of these agencies and specialists are:

1. Guidance Clinics and Other Provincial Facilities

   a. The Alberta Guidance Clinics

   The 1966 report of the Division of Mental Health indicates that the Guidance Clinics, 85% of whose clients are under 21 years of age, have a continuing liaison with the schools. In many of the rural areas of Alberta they are the only testing and para-educational service available. Referrals to the Guidance Clinics by schools (about 27% of their total new referrals) annually exceed the number of referrals they receive from other sources, such as the children's parents (26%) and those originated by the medical profession (21%). New clinic cases in the school age group (6 to 16 years), comprise three major diagnoses: Transient Situational Disorders (42%); Mental Deficiency (18%); Personality Disorders (15%).

   These diagnoses, comprising about 75% of the new school age clinic cases, do not describe pervasive and debilitating conditions, which preclude the person's attendance in regular school classes. In other words about 75% of the Alberta Guidance Clinics' new patients must be the concern of a teacher in a classroom on a daily basis. The remainder (about 25%), include children who are either "normal" or who are so disabled as to require placement outside a regular school program. Frequent consultation between the schools and the Alberta Guidance Clinics is, therefore, imperative, particularly because the staff of the Clinics rarely have teacher training but are frequently involved in making recommendations of an educational nature, such as special class placement, staying out of school and vocational choice. This is particularly true in rural areas where, as indicated previously, pupil personnel services are usually non-existent.

Recommendations, which primarily affect education, are made in about 25% of all new school-age Clinic cases, while recommendations involving treatment in the Clinic (about 23%), and modified home management (about 23%), run a close second and third. In the two major urban Alberta areas, it is not unusual for the special services division of the school board and the Guidance Clinic to confer on cases of mutual concern on a weekly basis.

b. Linden House and Alberta School Hospital

Linden House, Red Deer, which is a residential treatment home, and the Alberta School Hospital, Red Deer (for mental defectives), jointly employ about 18 school teachers according to the 1966 report of the Division of Mental Health.

c. Mental Hospitals

The 1966 Statistics of the Alberta Hospitals, Ponoka and Edmonton, indicate the presence, in their patient population, of children under the age of 15 years and therefore of school age. These data show no indication of any educational arrangements having been made for these children and the admission diagnosis of "Primary Childhood Disorders" would not necessarily indicate an incapacity for scholastic achievement.

2. Provincial and Municipal Welfare Agencies, Department of Child Welfare, Social Service Department

There is naturally a great area of overlap between the interests of the schools and those of the family-serving agencies. The schools are indirectly involved in public assistance or social allowance cases of social service and welfare agencies, usually in referring eligible applicants to the appropriate services. It is often through the difficulties of the child in the school setting that a family requiring assistance comes to the attention of an appropriate authority.

The schools are involved, however, to a greater degree with those cases involving child protection and probation. The need for coordinated effort is apparent because of the numbers of children and the involvement of many agencies, particularly in centres of large population.

3. Family Service Bureaus, Jewish Family Service, Catholic Family Services

Special educational services arrange case conferences with the staff of any of the family services. Referrals and contacts are not as numerous, as in others mentioned, except in Medicine Hat where social workers of the Family Service Bureau participate in the headstart program.

4. Medical and Profession

Diagnostic consultation with medical personnel is fairly frequent in Calgary and Edmonton. Although the Edmonton Public School Board makes referrals, via the child's parents, to psychiatrists, they do not have a psychiatric consultant at their disposal, other than those associated with the local Guidance Clinic. The Calgary Public School employs two part-time psychiatric consultants. The smaller centres follow Edmonton's plan but may have to wait one or more months for a travelling Guidance Clinic psychiatrist to come to the area.

5. Speech Therapists

Referrals are frequently made by Edmonton school speech and hearing clinicians to the Speech and Hearing Department of the provincial Glenrose Hospital, Edmonton, through a medical doctor. Referrals from all parts of the Province can be made in a similar manner. However, only Edmonton and vicinity patients can arrange regular speech therapy sessions on a practical basis. In Lethbridge, the school boards pay a fee for service offered by the only speech therapist in the area, who is an employee of the local health unit. Medicine Hat and Redcliff separate and public schools share one speech therapist whom they "imported" from the U.S.

6. In-Patient and Short Term Psychiatric Treatment

Psychiatrists in charge of in-patient child treatment units in active treatment general hospitals frequently request from the school a very detailed picture of their view of the child prior to admission. Often detailed follow-up studies are also required, to determine the progress of the child on discharge. This service has proved invaluable because the teacher is one of the first people to become aware of a child's increasing disturbance, or of his gradual improvement. He or she is the only professional person in the community who can spend six consecutive hours in a confined setting with the child and observe him in a detailed clinical fashion. It is unfortunate that any school-age child refused admission to an in-patient treatment unit, for reasons such as poor prognosis, less than average intellectual potential, unavailability of one or both parents, multiple physical handicap in addition to the emotional one, must be handled, somehow, by a teacher, who is not a trained therapist, in a school system. This situation is even more tragic if the child involved lives in rural Alberta, where the schools do not have adequate pupil personnel services.

RECOMMENDATIONS

The school has a definite role in fostering good mental health within the community. This role is considered both necessary and justifiable. The school can be a powerful agent for social change within the structure of the larger community. However, it is a public institution and is supported by public funds. Therefore, its tasks must be approved and regarded as public responsibilities.

The following action is recommended to enable schools to assume a responsibility with regard to mental health.

1. There should be a shift in emphasis from methods of cure to methods of early discovery, diagnosis and prevention. It is here that the school has its primary responsibilities and its most effective role.

   During the past 40 years pupil personnel services elsewhere have progressed through three stages: Remedial, Preventive, Developmental. Services in Alberta are mainly in the remedial stage. Very little time, if any, is devoted to preventive services, mainly because crucial problems of pupils require immediate attention.

2. Most of the pupil personnel services provided in Alberta schools are concerned mainly with pressing problems because of the lack of professionally trained pupil personnel workers. The deficiency requires an extension of training programs which should be sponsored at the Universities in Alberta to meet current needs.

3. The Provincial Government should provide special grants to promote preventive services in pupil personnel departments of the various school systems.

4. The Provincial Government should sponsor or employ specialized pupil personnel staffs to work in rural areas, towns and small cities as "Regional Consultants." They might well be assigned to health regions and function in a coordinated manner with Guidance Clinics deployed in the same way.

5. Qualified guidance counsellors should be employed in full time counselling positions in all regions.

6. The organization of group meetings for parents should be considered as a means of securing understanding and support for more extensive services which are required in the interest of mental health.

7. A survey of the school population in Alberta should be conducted as a basis for planning services. Insufficient information is now available regarding the incidence and nature of the various problems (See Appendix 1 "How To Study Your School Population") outlined in this Chapter.

8. Provincial Guidance Clinics should diversify their services to meet needs of particular areas. Examples would include emphasis upon treatment rather than educational diagnoses in cities; closer liaison with schools in rural Alberta until pupil personnel workers become available.

9. Planners of programs, staff and facilities in mental health should recognize an increasing requirement for services in schools and elsewhere for seriously disturbed adolescents.

10. Administrators should allow public health nurses to join pupil personnel workers in providing services for children. In Alberta

cities, public health nurses are sometimes bound by practices which prevent them from participating in team approaches to social problems. All resources should be available to all children.

11. The principle of equality of opportunity in terms of education and mental health, should be extended to rural and smaller centres to the fullest possible extent. This implies an energetic attempt at local and Provincial levels to improve pupil personnel services outside the two large cities.

12. Continued close co-operation between the schools and Provincial Guidance Clinics should be encouraged, with emphasis on teamwork rather than duplication of services.

13. Educational services in Government institutions should operate with a full complement of trained pupil personnel workers as well as professionally qualified teachers.

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Appendix 1
Chapter 7

HOW TO STUDY YOUR SCHOOL POPULATION[1]

Population Summary

Key Number ☐

Total Present Enrollment ☐

1 Kind of Student	2* Estimated Percentage of General Population	3 Number to Expect in Your Schools or System	4 Number in Your Sample	5 Number in Your School or System (Actual or Estimate)	6 Number Receiving Adequate Care Now
A. Gifted	5% x ___ =	___	___ x ___ =	___	___
B. Slow learners	15% x ___ =	___	___ x ___ =	___	___
C. Mentally handicapped, trainable	½% x ___ =	___	___ x ___ =	___	___
D. Mentally handicapped, educable	3½% x ___ =	___	___ x ___ =	___	___
E. Defective vision	½% x ___ =	___	___ x ___ =	___	___
F. Blind		___	___ x ___ =	___	___
G. Impaired Hearing	1½% x ___ =	___	___ x ___ =	___	___
H. Deaf	½% x ___ =	___	___ x ___ =	___	___
I. Other Physical Defects	2% x ___ =	___	___ x ___ =	___	___
J. Defective Speech	6% x ___ =	___	___ x ___ =	___	___
K. Maladjusted	7% x ___ =	___	___ x ___ =	___	___
L. Malachievers		___	___ x ___ =	___	___
M. Environmentally Handicapped	20% x ___ x	___	___ x ___ =	___	___
N. Drop Outs.		___	___ x ___ =	___	___

* These percentages are not additive because the same child may be listed more than once.

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[1] From Bulletin #26 of the Illinois Curriculum Program.

CHAPTER 8

FAMILY PHYSICIANS AND THE PSYCHIATRIST

Section 1: Study Comments

Section 2: Brief of College of Family Physicians of Canada, Alberta Chapter

FAMILY PHYSICIANS AND THE PSYCHIATRIST

STUDY COMMENTS

Chapter 4 (Delivery Systems) and Chapter 6 (Manpower, Education and Training) have already referred to the relationship and partnership of family physicians and psychiatrists in the new mental health plan, which is proposed for Alberta. This Chapter is intended to present additional detail in support of the proposal.

The Brief of the College of Family Physicians makes it clear that they favour an integrated approach to health problems, both "mental" and any other kind of health. Their members now assume a considerable responsibility for mental health as part of total patient care. They wish to play a larger, but more coordinated role. Their members are distributed widely throughout the Province, making them a strong and essential resource.

Their limitations relate to their lack of specific and sufficient training in the management and treatment of more serious mental health problems and their already heavy commitments to patient care. Several means of offsetting the deficiencies exist. First, psychiatrists are available in Edmonton, Lethbridge and Calgary to serve as consultants to family physicians. Many outlying areas can be served by psychiatrists from those points, as in the case of Medicine Hat and Grande Prairie now. Second, psychiatrists could be located, if they can be attracted, in each of the proposed health regions, or regionally in any case, at Guidance Clinics, at the regional mental hospitals or as members of the staff of Medical Officers of Health. Third, clinical psychologists on the staff of Guidance Clinics could be used as consultants to family physicians and in a treatment role. Fourth, the College of Family Physicians could sponsor, with the support of university departments of psychiatry, short term courses in the management and treatment of mental illness. Such courses should be conducted in a manner which would make them available to the complete population of family physicians at the earliest possible time.

With regard to the work load of the family physician it should be noted that much of his practice now is concerned with mental health problems. The suggestions, noted above, would be intended to enable the physician to be more effective in handling such problems and to avoid having to send some to mental hospitals outside the community or region. A need for more family physicians, however, is quite apparent.

Psychiatrists as members of the Alberta Medical Profession, have gone on record in support of the family physician - psychiatrist relationship in the management and treatment of mental illness. Problems in their case focus on the shortage of psychiatrists(Chapter 6), their tendency to locate almost exclusively in large urban centres, and the one-to-one, patient - psychiatrist treatment approach, in which many psychiatrists were trained. Some may not be comfortable or effective as consultants and not be available for that role. In addition, like other specialists psychiatrists are not likely to locate in rural or small urban locations unless there are very special inducements. Notwithstanding an official position of willingness to assume the role of consultant to an increasing extent, therefore, it is apparent that there could well be problems in the delivery of adequate services.

On the other hand, however, there does appear to be a growing awareness within the profession that individual treatment, by psychiatrists, of all mental illness, even if it were desirable as a goal, is quite impossible. At the famous Menninger Centre, with a large psychiatrist/patient ratio in comparison with any other centre, only one-third of patients are receiving individual treatment; the rest are participating in a kind of group social therapy. Dr. Roy Menninger, President of the Menninger Foundation, was quoted last year as saying, "Direct, individual treatment will never be the answer. We'll never have the resources. Our focus is away from the individual and onto the networks - the family, the Friday-night bridge club, work."

Psychiatry appears to have entered another phase of development where emphasis is on social rather than individual therapy, more treatment of groups instead of individuals exclusively, attention to the present condition of persons with problems more than their past. Shorter treatment is definitely the order of the day and collaboration with other professional personnel, many of whom are non-medical, appears to be gaining recognition as a necessity.

The results suggest further promising, even exciting advances in the fight against mental illness. Mental hospital populations are being reduced sharply. Many people, who in earlier times would not be expected to get better, are returning to fuller lives outside of hospital. Others are treated promptly and released earlier from community-based hospital facilities. Many persons, who would have been admitted in other days, are being treated and rehabilitated without even entering hospital, through the work of various practitioners and clinics.

Many new graduates will be oriented toward "community psychiatry" and the urgent necessity to take all possible action against the development of chronicity. Meanwhile, the profession in Alberta faces a challenge to meet a clearly apparent need, which can not be satisfied through the individual efforts of psychiatrists with individual patients. The family physicians, and other professionals, have declared their readiness to assume a full measure of joint responsibility. Members of the Study became confident, as their investigations proceeded, that the response of both psychiatrists and family physicians will meet the need.

SECTION 2: CHAPTER 8

FAMILY PHYSICIANS AND THE PSYCHIATRIST

College of Family Physicians of Canada,
Alberta Chapter

Chairman of Committee,
A.H. Gretton, M.D.

ALBERTA MENTAL HEALTH STUDY

CHAPTER 8

SECTION 2

INTRODUCTION

Family physicians in the Province of Alberta have a part to play in the evolution of good care in the mental health field. It should be stressed that family physicians are interested in total patient care, and regard mental health as part of total health.

Other briefs will have documented the role of Government, the Alberta Hospitals, psychiatrists and other physicians, psychologists, social workers, public health nurses, education authorities and many other interested professional groups. The public at large has a responsibility for community health, and the C.M.H.A. is active in this area.

The family physician today is changing with the developing knowledge and needs of the times. He remains the physician of primary contact for both patient and family, being responsible for both comprehensive and continuing health care. In this, he co-operates with other health professionals including medical specialists and allied health personnel. Recent surveys show that he is regarded by the majority of patients as their personal physician whom they first contact and that he deals with over 80 percent of their problems directly. Also, he may co-ordinate the care given by colleagues and enables the patient to be put in contact with them by referral. In the area of mental health, many patients or potential patients by-pass the family physician for various reasons, though eventually the majority will come under his care.

Both in office and hospital practice, much counselling and minor psychotherapy is required. The opening of psychiatric wards in general hospitals in Edmonton and Calgary serves to underscore the relationship between physical and mental health. The artificial barrier is indeed being broken down.

"Considering the pattern of morbidity today, one may ask whether it is good for internal medicine to be divorced from psychiatry? Can it be good for internal medicine and pediatrics to be cut off as they are from the general spectrum of morbidity? Is not internal medicine too narrow a concept for contemporary needs? Instead of internists, should we not be producing totalists, capable of evaluating clinical problems in all dimensions, physical and mental; capable of assessing ecological factors in an illness; and of using the technical specialties whenever they are needed". (McWhinney, 1968)

THE PRESENT DAY PROBLEM IN MENTAL ILLNESS

The scope of the problem is wide, from early childhood through adolescence and early married life to middle life and old age with its chronic care problems. There are the strictly mentally ill, the emotionally sick, and the mentally sub-normal. Special groups include alcoholics and other drug addicts; the acutely disturbed teenager and the variety of upsets in inter-personal relationships in the family. With the many people, agencies and disciplines involved in the field of mental health, there is fragmentation of effort. Of course, poor communication between the various resource personnel is one fault, but also lack of public understanding of the help available is another major fault. Even some of those already active in the field of mental health are themselves not well acquainted with the work of others in the same field, and there is poor understanding at all levels. One such area is between the work of the Alberta Hospitals and of the family physician. There is little direct communication between the professionals involved though the patients are constantly changing to or from their own community to or from that of the Alberta Hospitals. The personal health needs of the patient are the special concern of his own family physician who will best know how these needs can be met if he is fully integrated in the community's mental health program. Besides the therapeutic agencies, there are the educational agencies and the police and judicial agencies, all of whose work is inter-related and this may be best illustrated by the disturbed adolescent's care. As one public health nurse commented, "If only we were under the same roof as the Guidance Clinic and the Social Welfare Agency, we could at least coffee together, and save needless repetition of effort". A social worker in another community remarked, "We were requested to help, but find that those who could refer, for example, clergy and physicians, are often hesitant to do so".

The differences in approach which exist between the public and private psychiatrist are described in other briefs.

In this province there are still many mentally disabled persons who have been kept in Alberta Hospitals for the majority of their lives. Active efforts are being made to deal with this situation and to prevent its recurrence where possible, and the co-operative effort of all agencies will be required before a satisfactory resolution of the problem is achieved. Modern day-care programs for example, which are relatively cheaper to operate, provide a challenge to the old established methods. At the present time we have yet to fully exploit these modern approaches. The system must allow for new concepts, brought about by modern research to be implemented in the field for testing without disrupting the whole program. The present day approach to mental health care lacks such adaptability.

THE ROLE OF THE FAMILY PHYSICIAN IN MENTAL HEALTH

The function of the family physician may be listed as follows:

1. Preventative
2. Educative
3. Diagnostic
4. Continuous care of less seriously disabled patients -- to maintain them in the community as active members of the community.
5. Continuous care of those in nursing homes or chronic care institutions and continuing care of those who are at home under the care of relatives.
6. The administrative care of those who have been referred for private psychiatric care in co-operation with the psychiatrist.
7. Joint care of those being shared with private psychiatrists in their management.

8. The acute care of those in general wards admitted by the family physician.

9. The care of those in selected psychiatric wards attached to the major general hospital.

10. Liaison with the community services in the field of mental health care, for example, guidance clinics, the welfare department of the city or province, hospital social workers and nurses, public health nurses and the V.O.N.

Family physicians are geographically located in the communities of the province. Whatever the size of the community, the family physician's basic responsibility remains the same. In the smaller communities, he tends to do personally that which may be done by other professionals in large communities. In contrast, the public mental health resources and their private counterparts are concentrated in a few major locations with a few occasional visits being arranged to outlying areas.

Modern day psychiatric care is becoming more community-centered and so the family physician's role is more relevant in the professional spectrum of all mental health care. In order to achieve the best results, team work is required. To be effective, this must begin in all the involved disciplines in the training years.

As an illustration of the interest and concern of the family physicians, the following are some of their comments:

1. "Regional hospitals should care for the mentally ill, and auxilliary type hospitals should care for the confused aged. Old harmless patients should be moved from mental hospitals to these facilities."

2. "Social work agencies are required provice wide and at present there is too little co-operation between these and family physicians. A complete list of such agencies should be available to family physicians."

3. "Adequate facilities should be available for teenage problems."

4. "Visiting consultative teams could be developed into an effective therapeutic tool."

EDUCATION OF THE FAMILY PHYSICIAN

"It is time for a new approach...........if doctors in general, and family physicians in particular are to respond to medicine's constant change and challenge." (Cochrane, 1968)

"The future family physician must learn to work with others as part of a comprehensive health team,.......health orientated,......the group leader, co-ordinating the activities of other professions."

".....Students destined for family practice will become integrators of health services and the key to referral processes for problems beyond their scope."

"We believe that if health care of high quality is to be readily available to the Canadian people, a corps of family physicians must be trained to provide a major part of such care."

"As modern medical care becomes more complex, there is greater need than ever before for the well trained family doctor." (Rice, 1968)

"The family physician looked after all members of the family in 86 percent of cases, and initiated nine out of ten referrals. Most were loyal to him and trusted him more than other doctors." (C.M.A.J., 1968)

"The medical curriculum has paid too little attention to the teaching of psychiatry and of the psychological aspects of health and disease...... There has been no lack of proposals on how to incorporate the great advances in the study of normal and abnormal behavior, as well as in the treatment of mental disorders. The Advisory Committee of the new Nottingham Medical School has whole-heartedly adopted the new policies and recommended that the teaching of the behavioral sciences should run as a thread throughout the preclinical and clinical courses." (British Medical Journal, 1967)

"The young physician preparing himself to offer continuing comprehensive care, needs to know people as well as their tissues and organs, medical histories and relationships as well as individual disease states, medical ecology as well as symptomatology. Work in psychiatry would give him some of this background and so would some materials from sociology and public health, for example, information on the interrelationships of families and illness." (Millis, 1966)

"The student should learn how to diagnose and manage most psychosomatic and emotional problems. He should become competent to deal with the common tensions, anxieties and depressions that initiate or complicate a substantial proportion of the problems with which the family physician will be faced. The student should learn how to recognize major psychoses and to provide for many patients the after-care which they require following discharge from a mental institution.

This discipline is one of the most important bases for a family practice program. Most of the necessary knowledge and skill can best be acquired through a program in which psychiatry is integrated with medicine and pediatrics. An adequate model of family practice must include this integration. In addition, there should be a significant graduate experience on a specialized psychiatric service with responsibility for the care of serious illness under supervision. This will enable the trainee to recognize major psychoses and to deal with psychiatric emergencies which constitute a major problem for family practitioners. Competence in the further treatment and management of major psychoses requires additional specialized training.

Community medicine is one of the unique components of family practice. This discipline should provide the student with an understanding of the principles of epidemiology and environmental health, familiarity with the health resources of a community and community organization for health, and appreciation of the roles and interrelationships of persons in the various professional and technical disciplines which provide health services. Community medicine should provide the student with an approach to the evaluation of the health problems and needs of a community and to the improvement of resources to meet community needs more adequately. It should help the student to understand the role of government, private enterprise, and voluntary organizations in modern health care. Also, it should enable him to understand the economic and psychosocial barriers to medical care faced by many patients, the various methods for financing health care, and the problems and issues involved in the adequate distribution of health care to the American people.

Educational offerings in community medicine are not adequate in most American medical schools and will have to be developed as new ventures in most family practice programs. They might well be integrated with models of family practice in the medical center and with preceptorships in peripheral communities. Exposure to the problems of community medicine should begin in the undergraduate medical school years, with supplementation in the graduate years. However, until better programs in community medicine are developed in the various medical schools, the graduate family practice programs may have to supply the entire experience.

Since this is a largely underdeveloped field, it can serve as an important area of research for an academic department of family practice. Trainees in family practice should be given an opportunity to participate in such research activities." (Willard, 1966)

"An understanding of psychiatry is indispensable to the family physician. A high percentage of the illnesses that confront a family doctor are, in whole or part, complicated by emotional disturbances. Because of his broad responsibilities in this area, particularly for continuing care, the family physician should maintain a close liaison with the psychiatrist." (College Manual, 1967)

The above quotations make it clear that the family physician's role of tomorrow will be as vital to medicine as ever. In the undergraduate years he should be instructed not only in the behavioral and social sciences and their application to modern medicine, but should have field experiences with those of the allied health disciplines. In this way, team work and mutual understanding will begin in the training years. His orientation to total health care, mental and physical will also be assured in this way.

The family physician in his special preparatory training should gain an understanding of emotional illness in a variety of settings. He should spend some time in an Alberta Hospital, a psychiatric teaching unit attached to a general hospital, a guidance clinic, and with a social worker as well as his core training in an Ambulatory Care Unit. He should have considerable experience in interviewing techniques, and (possibly as an option) in psychotherapeutic methods. He will need to understand the use of E.C.T. and of drug-therapy. Group and family dynamics should also form part of the course. Option courses should be available for those especially interested. Research methods should also be incorporated in the course.

SOME SUGGESTIONS FOR IMPROVEMENT

Improved mental health care can be provided for our citizens and can be provided economically.

1. It should be understood that the family physician is already well trained and equipped, and he is already situated in strategic locations throughout the province. As personal physician, he is in contact with the bulk of the population throughout the province.

   In order to improve the situation, he should be a better trained person and should be involved with the other disciplines concerned with mental health care throughout his training days so that a good working relationship is built up and maintained.

2. Better integration of community mental health services can be achieved not only on a provincial but on a regional level by co-operation of the Department of Public Health and the Department of Welfare. The guidance clinic for the region together with the Provincial Welfare workers and the public health team of doctors and nurses could share the same building, thus promoting at least good "coffee-room" exchanges. Such regional centres could be based on major population areas where there would also be a large general hospital and a group of physicians. Such good local facilities would attract a good calibre of health personnel of all types, including at least a part-time psychiatric specialist.

3. Such regional hospitals would have an area designated for acute mental health care. Psychiatric trained nurses would, of course, be a part of the hospital staffing and would work with the public health nurses and the social workers in patient follow-up. Even the smaller hospitals should have at least one psychiatrically-trained nurse on staff.

4. The large cities of Edmonton and Calgary present a separate problem. The developing psychiatric wards in the general hospitals together with the guidance clinics and the involved medical personnel including family physicians are already in co-operation. A recent course on "The Parametors of Family Practice" brought together such personnel and closer co-operation was recommended by the group.

   Ambulatory Care Units which are being developed by the two University centres would provide a natural training ground and focus for the integration of these services.

5. It is recommended that interested parties set up local area committees to work out recommendations based on local needs and present these to the Departments of Health and Welfare. One instance of need which should be noted is that patients and relatives of patients often have to travel great and uneconomical distances to obtain mental health care.

6. One area which requires particular mention is that of child and adolescent health care. It is recommended that a thorough study be made of this, and that improved care and facilities be provided as soon as possible. There are already the beginnings of such facilities available such as Child Care Centres and the Glenrose Hospital, and these could be used as a nucleus.

7. Progress is already being made in the area of the aging population through the use of the local auxiliary hospital and nursing homes for the less seriously disturbed patients.

FAMILY PHYSICIAN QUESTIONNAIRE

Some eighty replies were received from a questionnaire sent out to members of the College of Family Practice, Alberta Chapter. Half those who replied were in single and half in group practice. Half worked in cities of over 50,000 and half in smaller cities and towns.

Each physician had on an average a yearly caseload of eighty patients who required counselling and interviewing. On an average each doctor referred one patient a month to a psychiatrist, one every three months to an Alberta Hospital, and less than one to a social agency. This was reflected in a referral pattern where the majority only referred sometimes to social agencies.

The majority reported inadequate information from the Alberta Hospitals on the discharge of their patients.

Less than half indicated that in medical school training, psychotherapy as applied to general practice was lacking.

Concerning child care centres, two-thirds did not reply or stated that facilities were inadequate.

Only six reported lack of interest when dealing with psychiatric problems.

In summary, it can be fairly stated that despite his background training and pressure upon his time, the family practitioner deals with a great amount of mental illness and is interested in this field.

The above recommendations should prove to be practical and economical, and it is submitted that, if they are seriously considered and implemented as far as possible, there will be improvement in the care given to those who are mentally sick.

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CHAPTER 9

ACTIVE TREATMENT GENERAL HOSPITALS

Section 1: Study Comments

Section 2: Brief of the Lethbridge Municipal Hospital

Section 3: Brief of the Lethbridge Committee of the Canadian Mental Health Association

CHAPTER 9

SECTION 1 ACTIVE TREATMENT GENERAL HOSPITALS

STUDY COMMENTS

The use of community general hospitals in the management and treatment of mental illness is advocated for the following primary reasons:

a. Equality of treatment is required regardless of diagnosis.

b. Short treatment and stay in hospital should be the aim in the interest of economy and early recovery.

c. Maximum utilization of community health professionals is essential to the efficient operation of health services.

d. Evacuation to distant facilities should be avoided generally because of negative effects on well-being and recovery.

Active treatment general hospitals are strategically located throughout the Province. They are the community health centres for their localities. They require only improved facilities and the availability of psychiatric consultation for their effective operation in the mental health field. Their use in that connection is increasing in Alberta. The trend need only be accelerated by attending to the requirements, noted above.

The brief in Section 2 of this Chapter, from the Lethbridge Municipal Hospital Board, is reprinted in its entirety because of its relevance and excellence. It makes the case quite convincingly for greater use of general hospitals. It also firmly establishes the requirement for a psychiatric unit which would be functionally and administratively an integral part of the Lethbridge Municipal Hospital.

It is recommended that the unit be provided on that basis at the earliest possible date. The size of the unit should be based on the catchment area and the Yorkton ratio of active beds to population. Planning should be undertaken in the same manner as for an addition to the present hospital. The current Division of Mental Health, if it has not disappeared, should have only an advisory role to play in the design and no role to assume in the operation of the unit.

The brief from the Lethbridge Committee of the Canadian Mental Health Association is included because it provides interesting and useful documentation of the need and the estimated bed capacity.

CHAPTER 9

SECTION 2 ACTIVE TREATMENT GENERAL HOSPITALS

Lethbridge Municipal Hospital

Chairman, Board of Trustees,
Charles G. Virtue, Q.C.

ALBERTA MENTAL HEALTH STUDY

This brief has been prepared by the Board of the Lethbridge Municipal Hospital and represents the viewpoint of the entire Southern Alberta health community, as evidenced by the list of agencies supporting the Brief, and shown on Appendix A attached.

The brief is based on the acceptance of the "total treatment concept" for mental care. We accept the philosophy that the "whole man" should be treated, and so far as is possible, in his own community. The Board's studies indicate that this can best be accomplished by the integration of most mental health treatment facilities into the general hospital. Although the initial cost in providing these facilities in the community will be substantial, in the long run an economic saving and improved mental health care will be achieved. It is submitted that the community which supports this Brief is ready to accept the responsibilities which will descend on the community if this concept is adopted including any short term increase in costs which may be incurred.

The brief recognizes the shortage of psychiatrists and other trained personnel and the suggestions contained are designed to make the greatest possible use of the family doctor and existing hospital personnel in the treatment of mental illness. It is recognized that the plans suggested cannot be accomplished immediately but we urge that any new facilities intended for regional health care centres be designed to fit into the community treatment general hospital and that existing custodial care facilities be gradually phased out. The establishment of general hospital facilities will assist in this phasing out process by returning patients to these facilities.

A. The City of Lethbridge is in the centre of a regional health community which is bounded on the South by the Canadian-United States border, on the West by the Alberta-British Columbia border, on the North by a line drawn through the towns of Nanton and Vulcan, and on the East by a line encompassing the town of Bow Island. The City has a population of 38,000 people and there are approximately 170,000 persons in the regional health area referred to.

Lethbridge is a market and service centre and is from a practical standpoint regarded as the regional health centre for the area referred to.

Lethbridge presently has two active treatment hospitals. The Lethbridge Municipal Hospital has 192 beds and St. Michael's General Hospital has 218 beds. Each has a school of nursing. In addition, there is an Auxiliary Hospital with 100 beds, two nursing homes which provide 120 beds, and two senior citizens homes.

At the present time the only mental health facilities are ten beds set aside for psychiatric patients in the Lethbridge Municipal Hospital and a child guidance clinic operated in separate facilities in the City of Lethbridge.

The psychiatric unit located in the Lethbridge Municipal Hospital provides services to patients who are suffering mild depressions and in some cases, the unit does handle psychotics. During the year 1967, the unit provided treatment to 241 patients. The service offers medical treatment by the family doctor in consultation with the private practicing community psychiatrist. The unit is staffed with psychiatric nurses. Occupational therapy is provided at the Lethbridge Auxiliary Hospital but recreational therapy is not provided at this time in this service. Treatments provided include E.C.T., psychotherapy and physical treatment on an inpatient basis. This psychiatric service cannot be described as adequate.

In addition to its hospital facilities, Lethbridge has a University and Junior College. There is an Agricultural Research Station with a large staff of highly trained university graduates. The Lethbridge Provincial Gaol is located just outside the city limits. The City of Lethbridge is well equipped with voluntary social welfare agencies including a new $1,000,000 family Y.M.C.A. building which is just being completed.

There is an active Mental Health Association and this organization together with the Chamber of Commerce has been educating the public about mental health and together with the hospitals and doctors and many others in the community have been urging Government to provide improved mental health facilities for Southern Alberta. (See Appendix B.) There are 68 doctors practicing in the City of Lethbridge, most of whom are general practitioners. There are two psychiatrists, one in the employ of the Provincial Government and in charge of the Child Guidance Clinic located in Lethbridge, and the other is in private practice. There are a number of psychologists connected with the University of Lethbridge.

B. The brief recommends:

(1) That mental health facilities in the Province of Alberta be decentralized.

The advantages are seen to be:

a. A greater ability to provide continuing mental health care. Because there is a shortage of trained psychiatrists, almost all mental health problems will be dealt with first by the family doctor and we believe it essential that he should remain in contact with and be ultimately responsible for his patient until he is returned to his regular life in the community.

b. There is a stigma attached to the present Ponoka type of centralized institution.

c. Would facilitate visits from family and friends. Now by reason of time and expense, they find it difficult if not impossible to visit the centralized mental hospitals.

d. Permit an easier return to the community environment.

e. Permit the weight of concern of the community to be brought to bear so as to keep mental health facilities up to standard.

f. Permit earlier diagnosis, treatment and admission to hospital.

g. Permits less disruption of normal life pattern.

h. Permits the use of the resources of the home environment.

i. Permits day-night treatment.

j. The location of the mental health facilities within the community would result in a greater community understanding and acceptance of mental health problems.

(2) Integration of administration of physical and mental health services on both provincial and local level:

a. Provincial level: One government department should administer all health care, be it physical or mental. This is a recommendation of the Revenues and Expenditures Committee in its report to Government dated October 1965.

1. Remove the existing discrepancies between the standards of mental health care and physical care.

2. Provide an easier comparison of standards of care between mental and physical facilities.

3. Contribute to economy of administration.

b. Local Government:

1. There should be a concerned group of elected citizens directly in charge who will insist on proper standards, and educate the community to support them.

2. There would be a greater opportunity for the family doctor to be part of the administration of the treatment centre so he would feel a greater responsibility, and take a greater interest.

(3) Integration of Mental Health Facilities into a general hospital:

a. Recognizes the psychiatric patient as a medical problem.

b. Tends to remove the public stigma presently connected with mental health.

c. Makes a greater use of the family doctor who daily practices in the general hospital, and will be encouraged to follow up and take responsibility for his patients after a diagnosis of mental illness. There is a shortage of psychiatrists, psychiatric nurses and other personnel needed in the treatment of the mentally ill and every effort must be made to use the family doctor, the general duty nurse, and other general hospital personnel. We are satisfied that this can best be accomplished by total integration of the mental health treatment facilities into the general hospital.

d. Permits an easier hiring of staff because general hospital employment is a more acceptable environment.

e. It recognizes the overlapping of physical and mental health problems.

f. It makes immediately available all of the facilities of the physical illness treatment plant for the mental health patients.

g. It would tend to immediately equalize standards of care between the mentally ill and physically ill.

h. It would permit and encourage a greater cooperation and communication between the psychiatrist and the family doctor.

i. It would upgrade the family doctor's training and qualifications in the care of the mentally ill.

j. It would facilitate an easier transfer of the care to the total control of the family doctor and hence, back in the community.

k. The medical and nursing staffs would have a better opportunity to become interested in and concerned for the improvement and upgrading of mental health facilities in a hospital for which they had some responsibility.

l. A greater economic benefit will be realized in the long run from monies spent on active treatment and prevention of mental illness than from monies spent on custodial care.

(4) We recommend the location in one building of almost all mental health services including:

a. Child Guidance

b. Inpatient, with emphasis on active treatment

c. Physical treatment facilities such as occupational therapy

d. Day Treatment service

e. Night Treatment service

f. Outpatient service

g. Consultation service

h. Emergency service

i. Facilities for the treatment of alcoholism and addiction

j. Office for home care program.

We believe that such a centralization of mental health services would have the following advantages:

a. Provide a comprehensive program - provide a structural program of mental health care so as to eliminate gaps and overlaps.

b. Provide a comprehensive record keeping service and thus facilitate a greater degree of follow-up.

c. It would permit all facilities and services to be readily available and therefore better used.

d. Permit and encourage communications between all those concerned with the various aspects of mental health.

e. Cut down administrative and capital costs.

(5) We recommend that there should be specialized institutions for the treatment of the following:

a. Forensic

b. Emotionally disturbed children

c. Long term geriatrics

In stating this we believe nonetheless that every effort should be made to give diagnostic service and short term treatment for children and geriatrics at the mental health facilities in the general hospital.

(6) a. We believe that a program for the use of the active treatment hospitals, auxiliary hospitals and nursing homes should be adapted to the treatment of psychiatric patients.

b. We strongly urge the provision of a home care program operating out of facilities in the general hospital.

c. We recommend the establishment of offices and personnel in the general hospital who would endeavour to coordinate the mental health treatment resources--churches, Y.M.C.A.'s, schools, Alcoholics Anonymous, university psychologists, and every other facility in the community.

d. We recommend that use be made of a preventive health services program to encourage these community organizations which participate in the prevention, treatment and rehabilitation of the mentally ill.

(7) We recommend the development of services designated to prevent mental illness in the community:

a. In this regard we emphasize the use that can be made of school counselling programs with an effort to provide adequate facilities for referral treatment.

b. The emphasis should be on early detection and early treatment of mental illness in the community at a general hospital.

c. Specific recommendations for the Lethbridge area:
    i The immediate provision of a decentralized total mental health care centre.
    ii The facility to be an integral part of the general hospital.

iii The facility to include provision for the use of the related services mentioned in paragraph (4) above.

iv The facility to be administered by one elected citizens' board who would have the responsibility for the administration of the total facility including the general hospital, the psychiatric facilities, and other mental health services.

v That such a facility be administered by one Provincial Hospital Department responsible for both the physical and mental health care services.

In summary, this brief adopts the philosophy that mental health is a community problem which should be treated in the community. This can best be accomplished by treating the "whole man" in the general hospital; by encouraging a greater use of the family physician in the treatment of mental illness; by the development of a home care program and by employing and coordinating these facilities which already exist in the community for the treatment and prevention of mental illness.

APPENDIX A

1. Staff Nurses' Association, St. Michael's General Hospital
2. St. Michael's General Hospital Board
3. Alberta Association of Registered Nurses - Lethbridge Branch
4. City of Lethbridge Council
5. Member Hospitals of the Southern Alberta Regional Conference
6. St. Michael's School of Nursing

APPENDIX B

CHRONOLOGY:

In 1963, the physicians in Lethbridge, recognizing the need for psychiatric beds in the community, submitted recommendations to the Board of St. Michael's General Hospital to incorporate this unit at the time of the construction of that hospital's new services wing. These recommendations were accepted by the St. Michael's Board, and they proposed that ten beds be approved by the Provincial Government. This request was refused by the Minister of Health, stating that these facilities would be inadequate to meet the needs of the community and district.

In September 1964, the Boards of St. Michael's General Hospital and the Lethbridge Municipal Hospital proposed a resolution to a Southern Alberta Regional Conference meeting which represents the entire Southern Alberta Hospitals. These were endorsed and submitted to the Alberta Hospital Association to be incorporated into their brief to the Provincial Cabinet. The resolution accepted read as follows:

> "WHEREAS, psychiatric illness is recognized as constituting a major health problem and the care of psychiatric illnesses should be integrated with other hospital and medical services at the local community level
>
> BE IT RESOLVED, that this Regional Conference supports hospital authorities in Lethbridge in making representation to the appropriate authorities for the establishment of psychiatric services in a general hospital situated in the City of Lethbridge."

In the Fall of 1964, the Minister of Health met with interested citizens, which included the Mayor, Hospital Board members, Administrators of both hospitals, members of the medical profession, and the Chamber of Commerce and the Minister agreed to send three senior officials from the Division of Mental Health, Drs. McLean, Michie and Schrag, to inspect the present active facilities and to make specific recommendations on the establishment of a psychiatric unit in this city.

In January 1965, Drs. McLean, Michie and Schrag met at the Municipal Hospital with the same representative group and were unanimous in recognizing the urgency in establishing the unit, but had reservations regarding the availability of qualified personnel.

In January 1965, at a special meeting of the Lethbridge Municipal Hospital Board the following resolution was passed and submitted to the Minister:

> "That the Board of the Lethbridge Municipal Hospital is unanimously in favour of the establishment of a psychiatric unit in Southern Alberta, and that the Lethbridge Municipal Hospital would be able to provide two floors located in a new wing on the present hospital."

In May 1965, at the opening of the new services wing of St. Michael's General Hospital, Dr. Ross in an interview with the press indicated:

1. that a 50-80 bed unit would meet the needs of Southern Alberta.
2. that it would be an addition to the Lethbridge Municipal Hospital facilities.

In 1966, Dr. D.F. McPherson, of the local Chamber of Commerce, presented a brief to the Provincial Cabinet sittings in Lethbridge where the following specific recommendations were made:

1. Accept as a valid reality that essential health care, can not and should not be based on a regionalized priority system. It does not seem reasonable that South Albertans should wait until Calgary needs are completely met in this sphere of health care any more than they should have to wait for essential health care in any other sphere.
2. That the Minister of Health direct the Hospitals Division in consultation with the Board of the Lethbridge Municipal Hospital to proceed immediately with the necessary planning to provide a wing with 50-80 psychiatric beds to serve the 100,000-120,000 persons of South Western Alberta.

In October 1966, Dr. Donovan Ross indicated to certain members of the Lethbridge Municipal Hospital Board his current plans for the psychiatric unit. The Minister suggested that the proposed facility would be on the grounds of the Lethbridge Municipal Hospital, be administered by the Mental Services Division of Government, and that all local physicians would be permitted to treat their own patients in the new institution.

On June 14, 1967, The Chamber of Commerce Health Committee, including representatives from St. Michael's and the Municipal Hospital, representatives of councils of the various municipalities, local members of the Legislature, met and agreed to the following resolution which was forwarded to the Minister of Health:

> "that this meeting welcome the establishment by the Department of Health of the psychiatric unit, including facilities for acute and chronic care, day clinics, child guidance clinics on the grounds of the Lethbridge Municipal Hospital and strongly urge that the acute psychiatric care facilities be completely integrated with the Lethbridge Municipal Hospital, and the other facilities be attached to the Lethbridge Municipal Hospital."

On August 22, 1967, Dr. Schrag accompanied by a Provincial Government architect and engineer conducted a study of the facilities and of the Lethbridge Municipal Hospital to assess the possibility of the development of the psychiatric unit on the grounds. This report was filed with the Minister of Health.

On February 6, 1968, the Minister of Health in a reply to a letter from the Lethbridge Municipal Hospital stated that:

1. That he could not confirm that the mental health centre would be be on this hospital's grounds.

2. That the bed size for the centre to include children, adolescents and adults would be in the neighborhood of 65 to 75 in total.

3. That because of the present financial situation faced by the Province, the Minister could not forecast the completion date of the proposed facility.

SECTION 3 ACTIVE TREATMENT GENERAL HOSPITALS

Canadian Mental Health Association
Lethbridge Committee

D.F. McPherson, M.D., C.M.

ALBERTA MENTAL HEALTH STUDY

The Lethbridge Mental Health Committee supports completely the position of the Canadian Mental Health Association in its recognition of psychiatric illness and related disabilities as constituting a major health problem that is best managed in the interest of the patient by providing for his care at the community level in units that are a part of the active treatment hospitals. Very substantial support for this position is to be found in the following documents:

1. The Hall Royal Commission on Health Services - as follows "13. That the hospital construction grant regulations under the Health Facilities Development Fund be amended immediately to provide one half the cost of construction of psychiatric wards or wings in all general hospitals over 100 beds in size or of small regional psychiatric hospitals with up to 300 beds, adjacent to general hospitals, including the requisite out-patient facilities, and small units for the mentally retarded."

   "18. That the psychiatric units, wings or regional hospitals have organized out-patient departments, in-patient treatment and consultation service, twenty-four hour emergency service, and 'day' and 'night' care programs."

2. The following resolution is from a joint meeting of the Canadian Mental Health Association, Canadian Psychiatric Association and the Canadian Medical Association in May, 1964. "Whereas the care of psychiatric illnesses should be integrated with other hospital and medical services at the community level:-
   Be it resolved that the C.M.A., C.P.A., and the C.M.H.A. and their provincial organizations take every opportunity to stimulate and encourage appropriate general hospitals to establish comprehensive psychiatric facilities and services for the effective treatment of patients suffering from psychiatric illnesses and disabilities, and that these include out-patient, in-patient, day care and other necessary services."

3. The following recommendations of the Special Committee to the Metropolitan General Hospital Council, regarding psychiatric services for hospitals in the council, March 7, 1963, Calgary.

   1. The majority of psychiatric patients can be cared for best in acute general hospitals.
   2. That there be .5 beds per one thousand of population in general hospitals in urban areas and the same ratio in specific regions, e.g. Peace River.
   3. That where appropriate and on the basis of provision of .5 beds per thousand population, there be provided by the Provincial Government or other suitable agency, adequate training for medical and para medical personnel.

It is to be pointed out that there exists in Lethbridge and Southern Alberta a very real need for Mental Health Service Facilities in all categories. At the present time this area including Lethbridge city and surrounding district of approximately 170,000 persons, is supplied with a small 8 bed psychiatric unit in the Lethbridge Municipal Hospital which in the year past was able to provide services to only 240 persons, and a Child Guidance Clinic that does not have the requisite staff, and yet has responsibility for all of Southern Alberta including Medicine Hat. This area is served by two psychiatrists only one of whom is in private practice.

It is the feeling of the Lethbridge Mental Health Committee that this service could best be provided by the integration of a new psychiatric care unit into a general hospital setting, and this would envisage the administration of such a mental health care unit by the elected Board that is also charged with the responsibility of the operation of the general hospital. In this context, it seems obvious that the Lethbridge Municipal Hospital would adequately meet this criteria.

The reasons why this arrangement better serves the needs of the patients, of the people of Southern Alberta, and the attending physicians, has been well outlined in the brief presented by the Lethbridge Municipal Hospital Board, with which the Lethbridge Mental Health Committee fully concurs, therefore they will not again be restated.

Specifically then, we would recommend the immediate provision of a Mental Health Care facility of approximately 80 to 100 beds integrated into the Lethbridge Municipal Hospital, this unit to provide for in-patient, day, night care, child guidance, out-patient, emergency and facilities for treatment of alcoholism. The Committee further recommends that this unit be administered by the elected Board of the Lethbridge Municipal Hospital.

CHAPTER 10

REGIONAL MENTAL HOSPITALS

History

The development of provincial mental health services is described in detail in an excellent presentation of the Division of Mental Health, dated July 1968. It is published in Vol. 2 of this report. A few summary statements will be recorded now as a background for the discussion of this topic.

> "Those requiring mental hospital treatment in the territory which became Alberta in 1905, and up to 1911, were sent to the Brandon Mental Hospital, Manitoba. The Provincial Mental Hospital, Ponoka, now the Alberta Hospital, Ponoka, was opened on July 4th, 1911, and patients from Alberta were transferred to it from Brandon. In all 164 patients were transferred in July, 1911. Also, during the last half of 1911 there were 52 patients admitted from Alberta.
>
> The Provincial Mental Institute, Edmonton, now the Alberta Hospital, Edmonton, opened in 1923 for male patients requiring continuing care. These patients were transferred from other provincial mental institutions, mainly the Provincial Mental Hospital, Ponoka.
>
> The Provincial Training School, Red Deer, now the Alberta School Hospital, Red Deer, was opened in 1923 for the training and care of mental defectives. Patients from the Home originally established in Edmonton were transferred to Red Deer, and the Home in Edmonton closed.
>
> The Provincial Auxiliary Mental Hospital in Clareholm was opened in 1933, and that in Raymond in 1939, for female patients requiring continuing care. These institutions are now the Alberta Hospital, Claresholm, and the Alberta Hospital, Raymond, respectively.
>
> Rosehaven, Camrose, was opened in 1947, for older male and female patients, many of whom are senile, who require continuing care. Most of these patients are 65 to 70 years of age and older.
>
> Deerhome, an institution for adult mental defectives, was opened at Red Deer on January 8th, 1958. It was constructed for this purpose through the Department of Public Works. The great majority of patients in Deerhome have been transferred from the other mental institutions in the province. There were 335 patients in residence on December 31st, 1958, made up of 175 men and 160 women. Deerhome is situated adjacent to the Alberta School Hospital but has its own grounds of some 28 acres. With additions constructed since 1958 it now has a patient population of 1,228, made up of 682 men and 546 women (December 31st, 1967).
>
> The patient population at the Alberta Hospital, Ponoka, increased as the years passed. By 1921, in November, there were 501 male patients, and 286 female patients, for a total of 787 in residence. The Table given below (Table 1) gives the number of admissions and discharges for the year and the number registered December 31st for each of the designated years.

TABLE 1

Year	Admissions	Discharges	On Books December 31st
1931	416	314	1,196
1941	557	516	1,637
1946	612	634	1,417
1951	654	594	1,539
1956	685	735	1,572
1961	1,068	929	1,269
1966	1,435	1,483	1,126
1967	1,313	1,412	1,027

The Table below (Table 2) shows the percentages of the patients discharged based on the time spent in hospital. These figures do not include deaths or those transferred to other institutions.

Figures are for the years given. The figures given for 1956 may be considered as representative for previous years. Percentages are given to the nearest whole number.

TABLE 2

PERCENTAGES OF PATIENTS DISCHARGED BASED ON TIME IN HOSPITAL

Year	Under 3 mos.	Under 6 mos.	Under 12 mos.	12 mos. & Over
1956	59%	19%	14%	8%
1961	61%	23%	8%	8%
1966	69%	18%	7%	6%
1967	67%	16%	6%	12%

In 1964 a foster-home program was established in Calgary, by the Hospital, in conjunction with the Canadian Mental Health Association. That year 24 patients were placed in eight private homes. Three of these patients were returned to hospital, six became self-supporting and fifteen carried on adequately in the community with welfare assistance. In 1966 there were 57 patients, 40 women and 17 men placed in foster homes in the Calgary, Edmonton and Red Deer areas. In 1967 fifty-one were placed, 29 women and 22 men. During 1966 there were eleven men place in "Roberts' House" in Calgary, and in 1967 fourteen men were placed there. "Roberts' House" is a half-way house. The Social Service Department assists, too, in placing elderly patients in nursing homes close to relatives, or home areas, when the patients concerned can be cared for in that type of accommodation. In 1966 there were 68 patients so placed, and in 1967 fifty-three. Similar work is carried out through the Alberta Hospital, Edmonton.

In 1960 a "Patients' Band" was organized in the Alberta Hospital, Ponoka, which has proved a worthwhile venture.

The Alberta Hospital, Ponoka, has used the "open-door" policy on about one-half of all wards for the past ten years. For several years before that this policy was being used to a lesser degree. For example in 1956 five units of the hospital operated as open wards successfully. The Alberta Hospital, Edmonton, has pursued a similar policy in this regard.

The total patient population (of Alberta Hospital Edmonton), admissions and discharges for the years given are as in the table below.

TABLE 3

Year	Admissions	Discharges	On Books Dec. 31st
1946	103	112	1,239
1956	794	730	1,641
1961	1,268	1,271	1,613
1966	2,094	2,142	1,470
1967	2,259	2,368	1,361

In the Table below (Table 4) the percentages of the patients discharged based on the length of stay in hospital are given. These figures do not include those who died during the year or were transferred to other institutions. The percentages are given to the nearest whole number. In 1946 the hospital was still essentially an institution for patients requiring continued care.

TABLE 4

PERCENTAGES OF PATIENTS DISCHARGED BASED ON TIME IN HOSPITAL

Year	Under 3 Mos.	Under 6 Mos.	Under 9 Mos.	9 Mos. & Over
1946	Figures are not available.			
1956	58%	20%	9%	13%
1961	62%	23%	6%	9%
1966	77%	11%	4%	8%
1967	79%	11%	4%	6%

The Alberta Hospital, Claresholm, was opened in November, 1933 in what had been the Claresholm School of Agriculture. The building was altered to make it more suitable for its new use, and on October 31st and November 2nd, 100 female patients were transferred to it from the Alberta Hospital, Ponoka, then called the Provincial Mental Hospital.

The patient population has been increased to 341 on December 31st, 1967, made up of 105 male and 236 female patients. Male patients were accommodated for the first time in 1965, and trained male nurses were added to the staff. During 1967 construction started on the Staff Residence and MacLean Hall, a building for recreational activities and occupational therapy.

The Alberta Hospital, Raymond, has been maintained in its original role in providing continuing care for female patients, most of whom are transferred from other hospitals. The patient population has remained about the same, and on December 31st, 1967, there were 121 in residence.

Rosehaven, an institution for the care of older, usually somewhat senile mental hospital patients, was opened on December 10, 1947. The main three storey brick building was originally built as a Normal School before World War I. It was used during World War II as part of a Basic Training Camp for the Army and a number of buildings including one used as a hospital, were put on two sides of it. The main building was renovated for its new role and some of the other buildings were taken over. All patients, male and female, are transferred from other Alberta Hospitals, almost without exception. Rosehaven began with a patient capacity of 200. Late in 1948 there were 187 patients in residence, 105 men and 82 women. The youngest patient was believed to be 66 years old at that time. Rosehaven is under the charge of the Director, Mental Health Division, as Medical Superintendent. Medical care as required is supplied by the physicians of a Camrose Medical Clinic.

Since 1947, a number of new buildings have been constructed and some additions made to existing buildings. Three new dormitories were completed, one in 1954, one in 1955, and one in 1957. Also, a new roothouse, a new laundry, a carpenter shop, and a greenhouse were constructed.

The type of patient has remained the same since 1947, but the patient population has increased with expanding accommodation. There were 467 patients in residence on December 31st, 1967, made up of 247 male and 220 female cases. Since the patients are all in advanced years, there are a number of deaths each year. In 1967 there were 91 deaths from degenerative causes. The average age of death was 83.5 years.

Occupational therapy is carried on for those who can take part. Also recreational activities are initiated and encouraged. Movies are shown, particularly during the winter months, and suitable entertainment is provided for occasions such as Hallowe'en, Christmas, and Easter. Local community groups arrange concerts, local parties or visits, and car rides. Television and radio are available on all wards.

Religious services are provided by local clergy and visits are arranged as needed.

The Table below (Table 5) gives the admissions, discharges, and number registered for the years and date designated (for Alberta School Hospital).

TABLE 5

Year	Admissions	Discharges	Registered (December 31st)
1931	35	10	190
1941	62	27	251
1951	73	29	395
1956	62	62	698
1961	124	162	718
1966	163	102	922
1967	133	78	977

There are several differences between an active treatment Alberta Hospital, and the Alberta School Hospital. Patients at the School Hospital are not mentally ill, but mentally deficient, patients come to the School Hospital to be trained so far as possible and not to be cured of an illness; a patient's stay in the School Hospital is much longer, generally, than in an Alberta Hospital; and activities at the School Hospital are set up to a large degree with training in mind. There are as well low grade patients who cannot benefit from any educational program and who can take little if any training. The School Hospital operates regular school classes for those who can benefit, and sense training classes for others or for younger patients. Also other activities in and around the institution are used to help prepare the boys and girls to become useful and self-supporting people, so far as possible. The farming operations including the raising of both beef and dairy cattle, hogs and poultry are used to give training, each in its respective field. Also work in kitchen, dining room, laundry and sewing rooms gives training in these activities. Occupational therapy in such pursuits as weaving, leather work, knitting, rug making, basketry and woodwork can be useful and recreational. The pace of the work must be suited to the individual patient.

Group activities are encouraged for those who can benefit. In this area there is a strong Parent-School Association at Red Deer that has been most helpful. In 1955 a summer camp site was purchased for the use of School Hospital patients by this Association.

A certain number of patients are allowed to work out, usually on a day basis, under suitable circumstances.

Recreations include swimming, skating, bowling, table games, picnics, hikes, and of course summer camps.

The first appointment of a professionally trained Social Worker to the School Hospital staff was made in 1950. There are now two regular positions on staff for social workers. These staff members interview parents whose children are admitted, investigate work placement situations, and provide counselling services to discharged patients as seems required. They assist with general programs in the field of social work as well.

The dietary services, with a dietitian in charge are considered important and efforts are maintained to provide attractive and well balanced meals. The greenhouse facilities on the grounds are of definite help in these respects.

Deerhome, under construction since 1955, was opened for patients on January 8th, 1958. It had been constructed for the custody and care of adult mental defective patients.

Deerhome has a comprehensive program for occupational therapy and recreation. There are positions for eight Recreational Therapists, and fourteen Occupational Therapists and Occupational Therapy Aides. It is difficult to maintain a full staff. However, many and varied programs are available including various forms of handiwork, walking parties, physical fitness classes, swimming classes (downtown pool), skating in season, bowling, dancing, tennis, badminton, card parties, parties for special occasions, movies, special programs, trips outside to special events, and similar activities. Many local groups and organizations provide or assist in providing entertainment, recreational equipment and transportation to outside events such as home visits, religious services, and pleasure drives.

A number of patients have been able to work out at selected places of employment, under supervision. During 1967 there were twenty to thirty boys working out on a daily basis from May to October. Also 33 boys worked out on a monthly basis for an average of seven months of the year. Some 38 girls worked out on a daily basis in 1967 and nine on a monthly basis. All of these people received a nominal wage. Within Deerhome itself almost 400 male and female patients assist with routine work in various departments. It is considered that the occupational therapy aspect of the work was of basic importance, but some form of financial incentive for patients who work at the institution could prove beneficial.

No immediate further expansion of Deerhome is planned, although there is a definite policy to maintain and improve existing facilities.

Linden House is situated on the grounds of the Alberta School Hospital, and is under the direction and supervision of Dr. L.J. le Vann, Medical Superintendent of that hospital. The unit was organized in 1960 for emotionally disturbed children and adolescents of average or normal general ability, ranging in age from 5 to 14 years (inclusive). It was set up to accommodate fifteen boys and fifteen girls. The patient population has varied from 29 in 1960 and 20 in residence that year on December 31st, to a total of 22 during the year 1967, with 10 in residence on December 31st. The patient population has shown a consistently larger number of boys than of girls. Dr. le Vann states, "It has been our experience over the years that our major admissions have consisted of children who have come from homes of marginal or less socio-economic status. These have included homes where the parents were severely psychoneurotic, insane, alcoholics, as well as families on public assistance." It has been found that these children "acquired good habit formation and social acceptability" in a relatively short time at Linden House, in most cases. In many instances they were kept there long after they might have been discharged because to have returned them to their respective homes would have undone the good work accomplished, and there was no other place to send them. Foster Homes and Youth Hostels for the care of such discharged cases could be one solution to this problem."

A comparison of Saskatchewan and Alberta figures for patients in mental hospitals, 1956-66 follows:

	Sask. Total	Population	Alberta Total	Population
1956	3,591	880,665	3,768	1,123,116
1961	3,271	925,181	3,371	1,331,944
1966	1,761	955,344	3,215	1,463,203

Saskatchewan's reduction per 1000 of population is more than one-half; Alberta's, about one-third.[1] The difference relates to the concerted effort made in Saskatchewan to phase out the large, isolated mental hospitals, in favour of more effective treatment settings.

The remarkable approach to reduction was supported by empirical findings of McKerracher and others (Williams and Ozarin, 1967), which have been summarized (p. 380) as follows:

> "With the exception of dangerous psychopaths, all psychiatric patients can be treated in open wards in general hospitals.

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[1] Alberta's "reduction" also includes patients transferred from the two large mental hospitals to homes for defectives (e.g. Deerhome received over 300 in 1958). So Alberta's record is poorer than the one-third figure indicates. WRNB.

> General practitioners can greatly improve their therapeutic knowledge and skill in psychiatry by treating, in collaboration with psychiatrists, their own psychiatric patients in a psychiatric ward.
>
> Rural general practitioners can work in collaboration with psychiatrists and effectively deal with most of the psychiatric problems in their practice.
>
> To provide adequate psychiatric care, a general hospital should have proper emergency, home-care, and other community services.
>
> Psychiatrists should function more as consultants and less as general practitioners of psychiatry."

The Saskatchewan reductions, however, as indicated elsewhere, were accompanied by severe strains on community resources and led Frazier and Pokorny (1968) to recommend deceleration until those resources and the development of discharge criteria had caught up.

The above quotations from the report of the Division of Mental Health will indicate that care has been provided on a large scale, over many years, for persons who are judged to be mentally ill or defective. They have been cited to indicate another characteristic, that of more custodial care than active treatment. (p. 163-168, above).

Although many "patients" could function in a non-hospital setting, like boarding homes, they can not be released because there are very few other places for them. Action by the Government and communities, in close and continuing cooperation, is necessary if the population of mental hospitals (and homes for defectives) is to be reduced. It should be noted that reductions have taken place in mental hospitals notwithstanding an increase in population but much remains to be done when Alberta's record is compared with other places.

The Current Debate

This report is being written at a time when the concept of mental illness and the existence of mental hospitals are being attacked vigorously. Defenders of each, however, remain and still appear to outnumber the critics. A much larger group than either critics or defenders favor substantial modifications in the current delivery system; and a growing number favor behavioral descriptions to disease concepts.

Szasz (1963), a psychiatrist, contends there is no such thing as mental illness and that there should be no mental hospitals. He carried his attack into an even more public forum in a recent article in which he states, "In my opinion, mental illness is a myth. People we label 'mentally ill' are not sick, and involuntary hospitalization is not treatment. It is punishment." He goes on to say, "...what we call 'functional' mental diseases are not diseases at all. Persons said to be suffering from such disorders are socially deviant or inept, or in conflict with individuals, groups or institutions." (Szasz, 1969 : 55)

He receives support from Laing, another psychiatrist (1969), who also likens mental hospitals to prisons and is concerned about inmates losing their civil rights.

In a forthcoming book, which describes commitment to a mental hospital as a "last resort", Braginsky et al. will present evidence to show that many supposedly "hapless" patients in mental hospitals are able to govern their own activities and are highly motivated toward doing so. Milieu therapy, which is discussed in Chapter 20 and which is not in use here, makes use of those conditions with marked effect. Braginsky also will propose a new paradigm for the current psychiatric model of "mental illness" and an alternative to mental hospitals, which is quite unlike current health institutions, generally.

These and other similar points of view, supported by convincing evidence, simply can not be set aside. On the other hand, certain harsh realities must be faced and they indicate that regional mental hospitals are required as essential parts of the delivery system here and now. It is probable they will continue to be necessary, although on a reduced scale, for another decade.

The realities are these:

1. With a determined effort and the availability of boarding homes or other community facilities, it would be possible to reduce the population of mental hospitals by one-half or even two-thirds over 5 - 10 years. However, a point would be reached, as was the case in Saskatchewan, where many of the remaining patients probably would have to stay. Treatment orientation requires constant optimism but still there are chronic cases. For example, one patient, age 78, entered Ponoka at age 25. Now in Claresholm she has been in a mental hospital for 53 years. Another, age 80, was admitted to Ponoka at age 32, transferred to Claresholm in 1946 and has been there since. She has no known relatives and has not had visitors for 10 years. A lengthy list of similar cases could be compiled.

2. Not every family today wishes to have a released patient as a boarder, and we have not created a substitute for homes. Moreover, good care in a mental hospital is to be preferred to indifferent care, hostility or abuse. As one person said, when discussing this topic, "I would prefer to see a relative of mine in a well-run mental hospital than to have him hallucinating in someone's basement." It is not an easy matter to find suitable places for all patients who could be released and to ensure that they provide satisfactory care regularly. Every effort should be made to do so but some degree of failure is to be expected.

3. Some people, admittedly a small minority, are not treated adequately within a general hospital setting and even the most convincing proponents of treatment at general hospitals make use of mental hospitals on occasion. Four examples will be presented later in this Chapter. To these examples should be added the persons detained on a Lieutenant-Governor's warrant, the criminally insane, some psychopathic non-offenders and other unusually difficult cases.

4. Some people should not be treated in a general hospital within their own community, notwithstanding the general argument in this report in favor of continuity of care. In some cases, removal from the scene of conflict is desirable, if not essential; and even

permanent divorce from precipitating influences (but not hospitalization necessarily) may be indicated.[1]

5. Some people are out of place in a general hospital because: they may need a special kind of treatment; or treatment over a longer term than is reasonable, if the general hospital is to be "active"; or treatment in a different facility. Examples are emotionally disturbed children and adolescents, addicts (after detoxification), or persons, who are more likely to respond to a larger, more structured milieu, which could be provided in a special facility. Sometimes, also, it is essential not to increase the strain on a family, which is already weak, by retaining the disturbing element close at hand.

The four examples, referred to in #3, above, follow. They are based on recent, actual case histories, with certain particulars omitted to prevent identification.

Case History #1

Mrs. Z.

Mrs. Z. is a middle aged woman who was transferred to the mental hospital from the psychiatric unit of a general hospital. The patient had been admitted to the psychiatric unit of the general hospital on her own request. On the psychiatric unit she was "hostile, resistive, dictatorial" and would not cooperate with the investigations and treatment. Mrs. Z. was sent to the mental hospital as it was felt that she required the "protection of a closed institution", where the patient could not dictate what investigations and treatment procedures were to be carried out.

Case History #2

Miss W.

Miss W. is an adolescent who has shown evidence of an emotional disturbance since infancy. During the girl's childhood the mother sought help from various agencies, but was always told "she will grow out of it". She was finally admitted to the psychiatric unit of a general hospital in early adolescence; however, after several months was transferred to a mental hospital as she would not cooperate and her acting-out behavior could not be controlled in an open setting. In the mental hospital she settled quickly and began to show progress. Arrangements were made for her to be readmitted to the psychiatric unit; however, within a very short time she was discharged completely from the general hospital as the nursing staff could "no longer cope with her acting-out behavior." The mother requested voluntary admission for the patient to the mental hospital again. During this second admission the patient was treated for a psychotic illness. She made good marks in her grade in the hospital schoolroom. Any acting-out behavior was readily controlled in the mental hospital setting.

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[1] Kubie (1968) makes the same point with greater authority, when he says: "The patient became ill in the midst of these normal contacts with home, job and community, among family and friends, among work and school associates! Why assume that this is where to help him find the road back to health?" (p. 262).

Case History #3

Mrs. S.

Mrs. S. developed a post partum psychosis and was admitted to the psychiatric unit of a general hospital. After several weeks she was committed to the mental hospital because of her "hyperactivity and increasing hostility", and interfering with other patients. The patient required active treatment, however, repeatedly threatened to leave the open setting of the psychiatric unit. In the mental hospital she responded well to treatment.

Case History #4

Mr. Z.

Mr. Z. is a middle aged, white male. He was admitted to the mental hospital from the emergency department of a general hospital. The accompanying information mentioned the man "needs the protection of a mental hospital". The patient had been apprehended by the police because of "irrational" and bizarre behavior in a public place. This man has had previous admissions to a mental hospital and his illness dates back many years. At the time of the latest admission, examination revealed the patient to be psychotic with many paranoid delusions. Further hospitalizations may be prevented or at least reduced by follow-up therapy.

The debate, which has been outlined, may one day be resolved in favor of abandoning *all* mental hospitals but that day has not arrived. Chapter 4 indicates their place in the proposed delivery system for the present. As our scientific knowledge advances, and new programs (including "community psychiatry") are evaluated, we should be ready to modify the system and its elements. There has been a static approach to delivery systems here and elsewhere over long periods of time. The one major lesson from the past is in this area. Briefly stated, it is that we should not permit ourselves to become restricted in the development of new kinds of mental health services through the creation of physical plants with long term treatment program implications. Another implication is that we must evaluate every program and discard those which do not work. Notwithstanding these lessons, which are clear to participants in the Study, the Government continues to plan more *mental* hospitals. It is agreed that the proposed community mental health centres, regionally and strategically located, and providing multiple services, would have been a great improvement on large, isolated hospitals years ago. But they would still be "mental" hospitals, perpetuating the old division of body and mind, psychiatry and other medicine, first and second class citizens. In terms of today's thinking, and hopefully tomorrow's, the concept was obsolete before it was advanced in Alberta. Health centres, not mental health centres, are required and the community health centre, today, *is* the active treatment general hospital.

RECOMMENDATIONS

1. The present mental hospitals should be retained and improved to serve in a regional and specialized capacity in the new delivery system. (See Chapter 4.)

2. Improvements at Oliver, Ponoka and Claresholm should take the form of developing special programs of active treatment for well defined groups, as discussed in this report. Minor physical modifications to facilitate segregation of certain groups will be required.

3. Special programs will require special staffs and they should be recruited or trained (as in the case of the forensic specialty) with despatch.

4. The observations made regarding Patient Care (in Chapter 3) should receive prompt attention.

5. If it is not clear from the presentation in Chapter 5, it is emphasized now that administrative authority should be delegated to local boards of these hospitals; that they should cease to come under a special section responsible for "mental" health; and that representatives of the hospitals should also be members of local and regional coordinating councils.

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CHAPTER 11

COMMUNITY FACILITIES AND RESOURCES

This topic refers to all elements of the first and second echelons of care (Chapter 4). It is also intended to include the many voluntary associations and agencies which are engaged in some form of mental health service. Some of the elements will be named for the convenience of the reader: health units, pupil personnel services, guidance and alcoholism clinics, voluntary agencies (e.g. V.O.N.), welfare units, family physicians, consultant psychiatrists, active treatment general hospitals, auxiliary hospitals, special hospitals or facilities (e.g. a children's hospital with educational and psychiatric services) and the various rehabilitation units (sheltered workshops, half-way houses, etc.).

The above elements are all based in "the community" but they now come under many jurisdictions, provincial, municipal, hospital boards, etc., or they are classifiable as private enterprise. If they functioned in a cooperative manner and in a few cases were more adequately staffed (e.g. pupil personnel services, guidance clinics), there would be less need for concern about prevention of mental illness and rehabilitation of those who have been ill.

Unfortunately, there is lack of coordination everywhere. In the communities surveyed during the Study over 70 percent of the agencies reported they supplied rehabilitative services for the mentally ill. However, they operated independently, often in competition with one another for scarce professional staff and sometimes providing service for the same family. In addition, there was ample evidence of lack of cooperative effort in the operations of other elements of the two echelons. The need for coordination of at least clinics, welfare and health units was recognized by many people. Medical Officers of Health were particularly concerned and several proposed a formal or informal union of the clinics and units in one location in the interest of reducing present waste of money and effort.[1]

One Public Health Nurse told of meeting a professional welfare colleague from the same centre, in a minor vehicle mishap, one going to visit a family, the other returning from a visit to the same family, neither aware of the other's interest, until the accident. This lack of coordination and waste of professional talent is evident also in the very presence of welfare units and clinics engaged in similar functions with nothing in sight but continued growth, independent operations and increasing costs. This situation is not peculiar to Alberta. It was reported last year from an eastern city that one lady, an out-patient from a psychiatric unit of a general hospital, was also receiving assistance from a dozen agencies.

It is clearly not sufficient to argue in favor of "community" mental health services. They are not the answer to the problems of prevention and rehabilitation. Coordinated community services should be the objective. The proposals concerning organization and administration (Chapter 5) are intended to help attain that objective. Local boards, local coordinating councils and regional coordinating councils whose concern is the whole health services field have been recommended.

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[1] See Recommendations #188-193 of the Report of the Special Legislative and Lay Committee Inquiring into Preventive Health Services in the Province of Alberta (the Ball Commission, 1966).

In addition, two other recommendations should be considered. First, the integration of health and welfare units, alcoholism clinics and guidance clinics under one administrative head, preferably in the same building would contribute to more economical and more effective operations. This recommendation implies one channel of communication and one responsible agency at the provincial level. If that is not acceptable in terms of broader organizational implications, at least a collaborative relationship of the named elements should be worked out. The M.O.H. is the logical central figure in either case and a model arrangement appears to be emerging in Edmonton.

Second, a detailed study of voluntary agencies concerned with mental health and extensive discussions with them should be undertaken to assess that resource and try to determine how the agencies might cooperate in the general interest. It is proposed that the Canadian Mental Health Association, under contract from the Government, assume that responsibility. The agencies now expect public support; it is only fair that the public should know their support is being applied in an efficient manner.

The operational efficiency of community facilities and resources in the delivery system proposed in this report is critical to its success. One other system, which has an enviable record, the Saskatchewan mental health service, came upon difficult times because community resources were overtaxed by a high rate of release from mental hospitals. The results led Frazier and Pokorny in 1968 to recommend "that no heroic efforts be made at this time to reduce the in-patient population at Saskatchewan Hospital, North Battleford" (p. 16); and "that for the present there be an easing off in the pressure for discharges from Weyburn Main Building, no matter what the effect on hospital census." (p. 15). The Saskatchewan achievements are commendable in general and Alberta should try to equal them at least. However, the pitfalls are apparent and must be avoided.

Just as the existence of community services is not sufficient to ensure their effectiveness, it is important not to consider "regionalization" of authority, in itself, a panacea. Dr. R.O. Jones, one of Canada'a foremost psychiatrists, and a consultant to the Study cautioned its members on this point a number of times. It should be recognized that there will be competent, interested and devoted local boards and there will also be others. Delegation of authority and regionalization of services have been supported by this Study because, on balance, it was concluded that local authority would do a better job in the whole health field than a central authority. Study members were influenced in this decision by the superior quality of service and administration in one health service over the other (hospitals : mental health).

In developing community resources for prevention and rehabilitation, planners should concentrate on programs and personnel, not physical facilities. Family life education is a promising form of attack and it requires personnel only. (In this regard it should be noted that pupil services, the clergy, health professionals and non-professionals represent the agencies through which this type of education can be advanced most appropriately. They require training for the job, however.) Day "clinics or hospitals" where people can come for help with their problems and return home at night do not have to be specially constructed and designed to last for years. Some flexibility is necessary to permit a shift from one kind of program in rehabilitation, or prevention, to another which has more promise. As stated elsewhere in the report, it is essential not to have mental health programs in the future determined in large measure by the existence of inappropriate buildings or locations.

> "A common conception of prevention often obfuscates thinking and action, namely, that little can be accomplished short of major social overhaul. Prevention of mental and emotional disorders is seen as the exclusive result of the abolition of injustice, discrimination, economic insecurity, proverty, slums and illness. To seek less is to attempt to fell a giant sequoia with a toy axe." (Bower, 1967 : 257).

It is agreed that, to some extent, society has the amount and kind of mental illness that it deserves. But it may just be possible to "fell" the "giant sequoia" if more than one small axe is used. It is clearly apparent that mental illness can be reduced by bringing many resources to bear on it, as recommended in this report. It is much less apparent that it can be prevented, even if a new society could be created, but surely the attempt must be made. To refrain would be to surrender without a fight.

RECOMMENDATIONS

1. Through consultation between appropriate authorities, the integration of health units, guidance clinics, alcoholism clinics and welfare units should take place on a regional basis. Wherever possible, these facilities should be under one administrative head and in the same building.

2. The Government should contract with the Canadian Mental Health Association to survey community facilities which are available for the rehabilitation of persons who have been mentally ill and recommend means by which they could function in a coordinated manner. Specific recommendations should also be submitted on additional facilities which may be required.

3. Training of health professionals and non-professionals should include content and approaches appropriate to family life education.

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CHAPTER 12

EMOTIONALLY DISTURBED CHILDREN AND ADOLESCENTS

Committee

Chairman:	Dr. D.O.C. Rapier	Department of Psychiatry University of Alberta Edmonton
Members:	Dr. H. Barker	422 Medical Arts Building 11010 Jasper Avenue Edmonton
	Dr. W. Bobey	Division of Mental Health Guidance Clinic Edmonton
	Dr. I. De Coutere	Marchand Mansion Edmonton
	Rev. W. Irwin	Catholic Charities Edmonton
	Mr. S. Millman	Division of Social Welfare Calgary

INTRODUCTION

This Chapter is based in part on a report prepared by the Study Group on Emotionally Disturbed Children and Adolescents. It will deal with concepts expressed elsewhere (Principles - Chapter 1; Organization and Administration - Chapter 5; Manpower, Education and Training - Chapter 6; and Pupil Personnel Services - Chapter 7) but from the standpoint of the provision of adequate treatment for emotionally disturbed young people.

Coordination

The governmental departments of Health, Welfare, Education, Attorney General, and Youth, voluntary agencies, the school systems and private practitioners are all involved in the delivery of care for emotionally disturbed children and adolescents. Coordination of the efforts of all concerned is a primary requirement if care is to be delivered economically and effectively. At present, there would appear to be competition between governmental departments, particularly for scarce professional personnel; and programs seem to be developed somewhat in isolation because there is obvious overlap.

To achieve the necessary coordination of the more closely related departments and functions, it could be argued that Health and Welfare should be unified at all levels, provincial, regional and local. In any case, it is clear that senior officials of health - related departments should confer and meet frequently to review and coordinate planning and programs. This approach is required by regulation in Ontario, as indicated in a White Paper tabled by the Honourable M.D. Dymond in the Legislature (1967). Whatever the organizational solution might be, there is a continuing need to ensure that the subject of child and adolescent care, from the standpoint of all departments named, should be approached on an interdepartmental basis.

It is interesting to note, in elaboration on the subject of coordination that the Department of Welfare's diagnostic centre in Edmonton is performing a health-related role. A recent advertisement notifies a requirement for a "Child Therapy Counsellor" to be concerned with "a unique therapy programme for the emotionally disturbed child...". Integration of that centre with the Department of Health's guidance centre in the same City would seem sensible and economical. Similarly, the Department of Youth is perceived as straying into the parishes of other departments in the search for good works. They appear to be alert to the need for coordination, however, as is evident in the case of the committee examining drug usage among juveniles. A study of "drop-outs" might reasonably have been undertaken by the Department of Education or on contract from the Human Resources Research Council. A proper research project on drug usage by juveniles might also have been commissioned by the Council. In the interest of achieving a greater measure of coordination, perhaps fewer departments of Government would be a good idea.

As mentioned elsewhere, a desirable form of field integration would be a grouping, by proposed health regions, of provincial welfare facilities, a guidance clinic, an alcoholism clinic and a health unit, all under one roof and one administrative head. In fact, the walls of the various compartments might be taken down and the reduced, but integrated, organization could be brought together as a "health and welfare" unit.

The following paragraphs will deal briefly with some other interdepartmental interests. Welfare and mental health share the problem of identifying suitable foster and boarding homes. The Study Group on this subject emphasized the necessity to choose well, if recovery and rehabilitation, in the case of emotionally disturbed children or adolescents, are to be facilitated. As indicated in Chapter 4, community participation in this activity is necessary and the C.M.H.A. has been nominated in this report to organize that participation, with financial support from the Government. The alternative to an effective home plan is more institutions.

Education and mental health have many overlapping interests. The presence of pupil personnel workers in all areas would mean that the preventive and early treatment stations in mental health would be manned. Their presence in force is vital to the success of any mental health program. Emotionally disturbed children, who are also deaf or blind, are of mutual concern. The School for the Deaf in Edmonton should have help to permit it to assume its rightful responsibility for children, who are deaf and disturbed, but not psychotic. In addition, it should be apparent that it is unfair to expect a deaf child to get along well in a boarding home, far from his own home and people, while attending the one school in the Province, at Edmonton. Even less is being done for the blind child and the emotionally disturbed blind child in the Province. The deficiencies noted in this paragraph require interdepartmental study and corrective action.

The Attorney General's Department and the Department of Health also share responsibilities, which indicate the need for close and continuing liaison. Many young people, who appear before courts, are mental health problems, as defined at the beginning of this report. It is essential that psychiatric and psychological consultation be available to the courts as required, to help decide upon placement or treatment. Attention is invited to the McGrath report (1968: 29-30), where the inadequacy of current detention facilities is emphasized. They are located only in Edmonton and Calgary whereas the need is widespread and will become acute when the "juvenile" age is raised to 17. Consultative services for the courts (forensic) should be provided from whatever mental health facility is in the immediate region of detention centres.

Standards and Facilities

The principles of equal care, equal availability of care and continuity of care, as compared with other illnesses and other age groups, apply with greater force in the case of disturbed children and adolescents. Early treatment is one means of preventing more serious difficulties later in life. There is also the need to treat more than the child, if recovery is to be sustained; often the family is involved. Both of these facts support the proposition that children and adolescents represent a very special case. However, facilities for them are not located to a degree or in a manner which would permit the above principles to be applied. At the University Hospital, Edmonton, there is an in-patient, diagnostic (psychiatric) facility for children and adolescents. Disturbed children are treated at two other hospital settings in the Province, Glenrose Hospital and Alberta School Hospital, Red Deer. But south of Red Deer there are no hospital-based services for emotionally disturbed children and adolescents.

Many of the less severe problems can be handled, and should be handled, in non-hospital facilities. Such facilities exist in guidance clinics, welfare units, the school system, private agencies and health units throughout the Province. However, those facilities should be brought closer together functionally in the interest of improving services and making better use of professional staff. Local and regional groupings of services under local control would appear to be the answer to the need, at least from the standpoint of coordination.

Regionalization of existing services is not sufficient, however. An adequate standard of care and treatment in a region would require: a diagnostic and assessment service; in-patient treatment facilities of a particular kind, including provision for education; day-patient and out-patient treatment in association with special classes in the school system; emergency service, seven days a week; and supportive and rehabilitative services in the community. An adequate coordination of the elements noted in the previous paragraph, linked with family physicians and active treatment general hospitals, would go far toward meeting the major requirements. Special facilities, however, would still be required.

Medium term treatment and education of emotionally disturbed children and adolescents frequently require the provision of space, which is not always present at conventional hospitals and the young people often do not need the other costly facilities which are available at hospitals. Glenrose suffers in that regard. It does not have enough room to allow active youngsters the kind of physical freedom they need. It serves a useful purpose as a short term diagnostic centre, but most young persons, whose treatment programs have been mapped out, should be sent elsewhere for longer term treatment. It is suggested that Henwood might be used as a kind of residential school and treatment centre for emotionally disturbed youngsters in the Edmonton region. Even Henwood, however, with its relatively spacious setting, does not meet the needs entirely but it could be modified to do so. The kind of facility which is preferable for medium term treatment of young people, is a small cottage-type unit, capable of accommodating four to eight persons. Such units could be constructed economically and could be based on Henwood as the central facility. It is proposed that the same approach is essential in other regions to make treatment readily available.

Other possibilities, depending upon the nature of each problem, include boarding homes, where special attention can be given to individual children. Autistic children, who require constant observation and attention, if they are to recover, are examples of special problems which require special approaches.

Ponoka also has possibilities for development as a highly specialized treatment facility. Programs and related facilities could be provided there on a regional basis for seriously disturbed cases, with very little change in plant or personnel. Linden House also could be continued as a local facility, in close association with the local Guidance Clinic.

In Calgary, subject to the approval of all concerned, a combination of existing or developing services and facilities could be used to meet the need. The Foothills Hospital could be developed to provide short-term treatment, possibly in a children's wing or unit. The Children's Hospital might be selected for longer term care, including education and recreation which would be provided on the hospital grounds. The Guidance Clinic in Calgary already has a special interest and competence in the diagnosis and out-patient treatment of emotionally disturbed children and could be associated with the other facilities through a coordinating council. Staffing could be on a joint appointment basis.

Special children's facilities, in conjunction with the Lethbridge, Medicine Hat and Grande Prairie general hospitals, should be planned as their psychiatric units are developed.

The Study Group on this topic reported a serious lack of facilities for children below the age of six, particularly those with communication problems, perceptual defects and emotional disorders. This problem will require special detailed study.

They also noted that "acting-out" adolescents require more attention than is available now. It would include assessment to help decide upon treatment or placement of those who become offenders.

Staff

The findings of the Study Group on Manpower, Education and Training were reported in Chapter 6 and they cover this subject fully. It is only necessary to add that the Group responsible for the subject of disturbed children and adolescents were also greatly concerned about what they termed a "personnel crisis". They urge special action to provide consultant psychiatrists in non-urban areas and point to the matter of incentive pay (a "rural differential"), proposed by Frazier and Pokorny (1968), as a possible solution.

In addition, the Study Group on Emotionally Disturbed Children and Adolescents supported the view (Chapter 7) that pupil personnel workers are required almost everywhere outside the large cities to help prevent the emergence of secondary emotional problems resulting from lack of attention to primary difficulties in speech, learning, vision and reading.

Other Considerations

It is regretted that nothing more definitive can be presented on this important topic at this time. The incidence, the kinds of emotional disturbances and the degree of severity, in terms of required treatment, remain to be defined. Without that information, sensible planning of facilities, programs and staff can not be undertaken. The necessary information is not available and must be gathered as a matter of high priority. In the meantime, the best use should be made of locally available information to plan the use, adaptation and extension of facilities and staff in a co-ordinated manner throughout the Province.

The subjects of addiction, habituation and dependence on drugs or alcohol also fall within the scope of mental health and are of concern in relation to the subject of emotionally disturbed young people. They will be discussed in detail in Chapter 18.

Private agencies have information, resources and interests directly relevant to the subjects under discussion. They have taken a leading role in seeking solutions to the vexing human problems which face governments and communities. In that regard the 1967 report of the Edmonton Welfare Council, titled An Examination of Facilities for Emotionally Disturbed and Retarded Children, warrants careful study by the Government. In addition, such agencies should be brought into close association with health institutions and staffs in the proposed delivery system.

RECOMMENDATIONS

It is recommended that:

1. A province-wide demographic survey be undertaken to determine the incidence, nature and degree of severity, in terms of required management and treatment, of emotional disturbances among children and adolescents.

2. A delivery of care system be worked out, initially along the lines described above, between local, regional and provincial authorities, making optimum use of available facilities and personnel and increasing them to meet needs as they are defined.

3. A consultant on child and adolescent care be engaged to advise on #1 and #2, above. Consideration should be given to a permanent appointment within the Department of Health, or a Health Commission, if that recommendation of this report is adopted.

4. Coordination of all agencies and programs concerned with the delivery of care in this context be assigned major importance in plans for improved mental health services.

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CHAPTER 13

INTELLECTUALLY AND NEUROLOGICALLY HANDICAPPED CHILDREN

Committee

Chairman:	Juanita Chambers, Ph.D.
Members:	E.W. Gauk, M.D., F.R.C.P. S.A. Perkins, Ph.D. J. Quinn, Ph.D. A. Teal L. Whyte, M.A.

INTRODUCTION

The objectives of this study were to provide an objective province-wide assessment of resources for intellectually[1] and neurologically handicapped children; to make some evaluation of the adequacy of these resources; and to make recommendations for the development of a comprehensive, integrated program.

The evaluation of resources was carried out by surveys and questionnaires, submitted to responsible persons, and on-the-spot visits to representative areas. Recommendations are based primarily on the direct representations of people in the field.

The following classification will be used:

1. Children of low I.Q. with neurological involvement.
2. Low I.Q. without gross neurological involvement.
3. Normal I.Q. with severe neurological involvement.
4. Borderline I.Q. with perceptual disorders.

"Low I.Q." was defined as below 50 on Binet or WISC; "borderline" was between 75 to 90 I.Q.

1. Low I.Q. with Neurological Involvement

To determine the types of problems involved with "trainable" (I.Q. 30-50), a questionnaire was sent to the institutions in Alberta where they are housed.

Twenty-one questionnaires were sent out. Four additional homes were listed, but one has closed and the addresses of the other three small homes could not be located. Ten completed questionnaires were returned. Baker Memorial replied that their patients are in the totally dependent category. The large Alberta School Hospital did not cooperate in the survey. However, two other institutions of comparable size, Winifred Stewart School and Deerhome, completed the questionnaire. Thus, the following results are based on approximately 50% of homes and that sample is judged to be representative.

The populations of the institutions

Except for Deerhome, the institutions house almost exclusively

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[1] Mr. A. Teal of the Alberta Association of Mentally Retarded was a member of this Study Group and, in addition, a brief from the Association is published in Vol. II. WRNB

trainable patients. Several reported a low percentage in the educable category (less than 10% in every case) and one reported 4 of 19 children were there for unspecified reasons. Deerhome reported 684 trainable in a population of 1357. The remainder are totally dependent. The Alberta School Hospital also houses educable and emotionally disturbed children but detailed figures are not available.

There are 1211 trainable[2] individuals in the 10 responding institutions. Of the 1211, five are under 6 years of age; 485 are of 6 to 18; and 726 are over 18.

The diagnoses for the 517 persons were:

Cerebral palsy	20	
Brain injury	226	
Epilepsy	28	(excluding Deerhome)
Down's Syndrome	164	
Other	29	
Unknown	50	

If cerebral palsy, known brain injury and epilepsy are grouped together, a total of 274, or approximately 53% of the 517, have neurological impairment. Approximately 33% of the cases exhibit Down's Syndrome.

Concomitant disabilities, excluding Deerhome, are: blind - 0; deaf - 3; mute - 3; chronic health problems - 17.

The Deerhome figures are presented separately because only 29 of the patients are below 18 years of age and the figures would distort the educational implications. The breakdown for Deerhome is as follows (684 patients):

Blindness	8	Epilepsy	166
Partially sighted	3	Crippled	175
Deafness	12	Diabetic	12
Mute	59	Psychosis	157

There is no accurate information regarding speech handicaps, partially sighted, and hard-of-hearing because very few respondents completed this section of the questionnaire. Where information was given, the speech handicap appears to be the most serious problem. The Lethbridge figures are typical: of 49 children, 34 have a serious speech handicap.

The figures concomitant disabilities are probably low because the two institutions admitting school-aged, multiply-handicapped children (the Aphasic School and the Robin Hood School) did not reply.

2. Low I.Q. Without Gross Neurological Involvement

The incidence of mental retardation in North America is estimated at three per cent of the population; in Alberta, on that basis, the figures would be 42,000 to 46,000. Various authorities would add "borderline" retardation. The American Association on Mental Deficiency estimate based on an I.Q. of 84-85 is 16 to 17 percent of the population.

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[2] The Mimosa Project in Kansas has indicated dramatically that persons, who would not be considered trainable normally, can achieve an impressive degree of independence and personal competence in a behavioral modification program. Such programs are needed in Alberta. WRNB.

Mental retardation is incomplete mental development. Intellectual growth of the individual becomes impaired before, during, or after birth. It is a condition distinguishable from mental or emotional illness in that the retarded person may, apart from this intellectual handicap, be a healthy, active individual who, within the limits of his intelligence can be responsive to training in vocational programs as well as to social and moral responsibilities.

The group of individuals, with low intelligence but without gross neurological involvement, comprises about 17% of the mentally retarded in Alberta and would approximate 8,000 persons. Present facilities for this group of children are both government-sponsored and private. The Association for Retarded Children operates in many centers in Alberta; the "crusade projects" and individual homes complete the private section. The Alberta School Hospital at Red Deer and the Baker Memorial Hospital in Calgary are examples of government projects.

Available resources comprise:

a. Local Associations for Retarded Children
(Note: Numbers are approximate.)

	No. Served
Calgary Association for Retarded Children	
Christine Meikle School	163
Emily Follensbee School	72
Pre-School and Day Nursery	25
Sheltered Workshop - Advance Industries	60
Camrose & District Association for Retarded Children	
Burgess School	19
Drumheller Association for Retarded Children	
Muriel E. Rowe School	3
Edmonton Association for Retarded Children	
Winnifred Stewart School	321
Grande Prairie & District Association for Retarded Children	
Peace School of Hope	52
Dormitory for Retarded Children (30 beds)	31
Cold Lake, Grand Centre & District Association for Retarded Children	
Class for Retarded Children (to open this fall)	10
Lethbridge & District Association for Retarded Children	
Dorothy Gooder School	51
Summer Camp (to begin this year)	30
Medicine Hat & District Association for Retarded Children	
George P. Vanier School	27
Summer Camp (to begin this year)	15

Red Deer Association for Retarded Children Parkland School	37
Strathcona (County) Association for Retarded Children Robin Hood School (includes some multiply handicapped) (new school planned to accommodate approximately 50)	28
St. Paul & District Association for Retarded Children St. Paul School (new school being built for 33 students)	15
Vegreville Association for Mentally Handicapped Children Dr. R.R. Cairns School	15
Vermilion Association for Retarded Children Vermilion School	8
Wetaskiwin & District Association for Retarded Children Wetaskiwin School (new school planned for 30 students)	19

b. The Crusade Projects

Centre for the Study of Mental Retardation - University of Alberta, Edmonton
Industrial Research and Training Centre - Edmonton
Vocational and Rehabilitation Research Institute - Calgary

c. Alberta Government Facilities for Retarded

Alberta School Hospital, Red Deer, Alberta Age 6 - 16 (very low I.Q. to 75 approx.)	854
Baker Memorial Hospital, Calgary, Alberta (being enlarged) Age 0 - 16 (very low I.Q. multiply-handicapped)	152

d. Private Facilities for Retarded

Welwyn Manor, capacity 44, ages 0 - 6

Mrs. Zoie Gardner, capacity 11, age 0 - up

Mrs. O. Beisel, capacity 3, ages 6 mo. - 3

Mrs. V. Stearnes, capacity 5, any ages

Wensley Children's Homes, capacity 9

3. Normal I.Q. with Severe Neurological Handicap

The extent of this problem in the Province is undefined because of inadequate statistics. The Registry for Handicapped Children and Adults provides the following data:

Total cases	2,029
Blind	591
Deaf	586
Polio	1,888
Cerebral Palsy	553
Epilepsy	641
Progressive Muscular Dystrophy	2
Late effects of Intracranial Infection	27

These figures are derived primarily from reports of public health nurses and birth and vital statistics.

The neurologically handicapped but intellectually normal individual can be quite productive in the community. There are, however, serious mental health implications if long range planning for employability and recreation is neglected in their training programs. At present, facilities for these children are limited, both in number and scope.

The Blind

Facilities for blind young people in Alberta consist of sight-saving classes for those with some residual vision. Those children requiring residential management are usually transferred to the Jericho Hill School in Vancouver. This school is reluctant to accept blind children with behavior problems, and frequently parents are reluctant to send their children to such remote facilities.

The Deaf

One major facility is available for intellectually normal deaf children in Alberta. This is the Alberta School for the Deaf which can accommodate in-patient children with hearing deficits.

This school, however, cannot cope with a deaf or hard-of-hearing child showing a behavior disorder. Such cases are then referred to the Glenrose School Hospital, where psychiatric help is available but where the teaching facilities for deaf children are currently inadequate.

Polio

Immunization procedures have virtually eliminated this disease. Facilities for the management of the sequelae of polio are in major Alberta hospitals and are generally quite adequate.

Cerebral Palsy[3]

The Glenrose School Hospital is an excellent facility, catering specifically to the intellectually normal or near normal children with cerebral palsy.

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[3] Attention is invited to the brief from the Cerebral Palsy Association, Calgary, at Vol. II. Their recommendations merit full consideration by the Government. They include: more attention for the very young, down to age 1; extended day care facilities; and cottage type residences instead of institutions. WRNB

In 1967 a total of 82 children attended the Glenrose School Hospital as in-patients. Two hundred and six children attended as out-patients and 124 as day patients. At present there are 26 children waiting assessment at the Glenrose School Hospital.

Epilepsy

Most epileptic children have infrequent seizures which can be controlled with anti-convulsant medication. However, the community as a whole still harbors many misconceptions about this disorder. Continuing efforts are necessary to educate the population that epileptic individuals normally can live quite productive lives.[4]

Progressive Muscular Dystrophy

This fatal, degenerative muscle disease fortunately occurs rarely in the Province. There is no known cure for the disease.

Late Effects of Intracranial Infection

Bacterial meningitis diagnosed early is less likely to cause neurological deficits. This disease occurs more frequently in poor socioeconomic circumstances and, in such instances, it is also diagnosed later. Improved public health facilities will decrease incidence and improve the management of the condition.

T.B. meningitis is still a scourge of the Indian population. The resultant neurological handicap is usually severely incapacitating. Continued measures to stamp out tuberculosis in Alberta are required.

Much can be accomplished to assure the productivity and the mental health of the neurologically handicapped, intellectually normal young people of Alberta. Lack of personnel is a major inadequacy plaguing this work. That deficiency is aggravated by a lack of sufficient training for personnel and inadequate counselling about training which does exist in the Province. There is also a lack of recognition and reward for those, who have acquired special skills in this field.

4. Borderline I.Q. with Perceptual Disorders[5]

The child of borderline ability was included because he represents a significant part of the population and his educational and other needs tend to escape sufficient notice. A summary of educators' opinions and estimates and some recommendations related to them will be presented.

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[4] The Alberta Epilepsy Association recommends an educational program to overcome public fears, superstition and misunderstanding about epilepsy. The Association also proposes a reassessment of persons on welfare or in institutions to update medication, if indicated. They also recommend that reference to epilepsy be removed from legislation relating to sterilization or mental diseases. These recommendations have my support.

[5] In addition to the recommendations to follow which are related to this section, the proposals submitted by the Canadian Association for Children with Learning Disabilities, Calgary, at Vol. II merit consideration.
WRNB

A questionnaire was sent to school superintendents in the Province. Forty-one of 63 addresses, representing 182,605 students, responded. The sizes of their school systems varied from less than one thousand students (1) to more than sixty thousand students (1). Mean system size was 4450 students; median size was 2400 students.

Definition of Terms

Borderline - a student who obtains an I.Q. score in the seventies or eighties.

Personality or emotional difficulty - noticeably withdrawn or aggressive (acting-out) behavior, or excessive attention-seeking behavior.

Achievement difficulty - one failed grade for each three passed.

Result of Questionnaire

The number of students indicated to have scored between 70 - 90 was 23,842 (13% of the 182,605).

Superintendents indicated that 15,843 or 65% of the borderline group experienced achievement difficulty; 8,639 or 36% experienced personality or emotional difficulty; 8,340 or 35% experienced reading difficulty. The percentage of borderline students with reading difficulty changes markedly when one large city school system is not included in the summations; the revised figure is 70.5%

Respondents estimated that 7,898 or 33% of the borderline group are reared in homes where a language other than English is spoken. If the large school system is omitted, the figure is 60%.

Instructional modifications to cope with the borderline students' needs were reported by 27 or 66% of the respondents for elementary school level, 19 or 46% for the junior high school level and 15 or 37% for the high school level.

With respect to predicted success on high school vocational courses and the attainment of journeyman status in a trade, there was a marked division of opinion among the responding superintendents.

	Voc. Courses	Journeyman Status
Agree	9	13
Disagree	6	10
No Comment	4	8
Qualified Comments	22	10
TOTALS	41	41

Thirteen percent of students were reported by superintendents to be in the "borderline" group, which is ineligible for placement in classes for educable mentally handicapped children. However, two-thirds of the borderline group are reported to experience failure or deceleration at least once each three years. Thirty-six percent are said to experience emotional difficulties, probably because of frustrations encountered with a curriculum designed for the average student. Thirty-five percent of the borderline group are reported to have distinctly inferior reading skills. When one large urban school system is omitted from computation, the latter figure rises to 70.5%.

Thirty-three percent of the borderline group come from homes where a language other than English is spoken (60% if the large, urban system is omitted). The latter percentage accurately reflects the disadvantage experienced by bilingual or English-learning students.

Sixty-six percent of the respondents indicated modifications in instruction were made at the elementary level; forty-six percent at junior high level and thirty-seven percent at senior high level. The figures probably reflect that many of these students "drop out" of school as soon as they are of school leaving age and do not enter high school.

Superintendents tended to indicate that voational courses offered in Alberta high schools are not designed for this group of students. Twenty-two respondents (54%) indicated that "some" or "a few" of the students could benefit from "some" of these courses. The questionnaire was not sufficiently detailed to permit elaboration, but the large proportion of superintendents, who chose to qualify their remarks, indicated the concern with which they view the situation. Nine respondents (22%) agreed that the courses were within the capabilities of these students while six (14.5%) disagreed.

Thirteen respondents (32%) agreed that such students could attain journeyman status in a trade, ten (24%) disagreed, ten (24%) offered a qualified statement to the effect that "some" students could succeed in "some" trades.

In summary, between ten and fifteen percent of Alberta students score between 70 and 90 on intelligence tests. Of this group, 65% experience achievement difficulty, 36% experience personality and emotional problems, and at least 36% have inferior reading skills. At least one third of the students are from homes where a second language is spoken. Marked variation of opinion among educators appears with respect to probability of success among these students with high school vocational courses and trades training, in large part because the training does not appear to have been designed to develop their full potentialities.

Study Group members visited four areas (Pincher Creek, Drumheller, St. Paul and Hinton) to obtain a fuller understanding of the problems associated with intellectually and neurologically handicapped children in the Province. Special attention was assigned to the following factors:

1. Staff/population ratio; staff training.
2. Employment of staff (as teams or individuals).
3. Physical facilities and special equipment.
4. Programs: diagnosis (frequency and check-up); referral practices; consultative resources; in-service training; appropriateness of programs.

The findings were remarkably consistent, although two different members visited each area and there was no prior consultation with any area. The evidence was supported by the Study Group's own experience and deliberations and by the strongly expressed judgments of professional persons in the field. The recommendations, which emerged, represent serious convictions on the part of each member of the Study Group.

RECOMMENDATIONS

1. It is recommended that services for intellectually and neurologically handicapped children be distributed, so far as practicable, to regions in the form of small training and treatment units, which would provide both day and residential facilities.

   The Study Group is greatly concerned about the present necessity to remove children from their homes and communities (defined even in a broad sense) for long periods of time. Several good centralized facilities and programs exist but placement in them divorces the child and his family and impedes the child's total development.

   Benefits, which would accrue from decentralization, include: the maintenance of family ties during critical years; provision of professional liaison with the families to help facilitate a progression from total residential care to day care service; and, possibly, greater community tolerance and support of rehabilitative and employment efforts.[6]

2. Operational authority over programs, staff, and facilities should be delegated to regional levels in the interest of making full use of local knowledge, support and concern. Central authorities should be responsible for operational guide lines, standards and financial support, only.

3. The growing multiplicity of government agencies, concerned with the health, education and welfare of children and their families, points to the need for at least coordination, if not integration.

4. It is strongly recommended that permanent local guidance clinics be

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[6] The Parent-School Organization, Alberta School Hospital, Red Deer, has reported that adjustments in labour laws are required to enable graduates of Alberta School Hospital to be employed. It is recommended that this reported restriction be investigated and, if necessary, be removed in the interest of attaining the fullest possible development of all citizens of the Province. WRNB.

established in all regions.

Lack of staff for diagnostic consultative and treatment services in all non-urban areas is deplorable. Periodic visits of travelling clinics do not meet the needs. Joint appointments to different school boards in one region or joint appointments to boards and a clinic might help to meet the need for the necessary cadre of professional personnel. Such personnel as clinical psychologists, guidance counsellors, social workers and case workers, are needed in sufficient numbers to serve the whole community rather than just one sector.

In outlying districts, the Government should offer special monetary and other inducements to secure personnel. The formation of organized cadres probably would facilitate recruitment and maintenance of staff.

5. It is recommended that school boards in outlying districts be given special grants to enable them to hire teachers of special education, and other necessary pupil personnel workers, according to their needs, with added monetary inducement, if necessary.

6. Teachers' aides for special retarded classes or for other handicapped groups should be provided.

The "pinning-down" of a teacher of exceptional children, without any other professional help, makes her a custodian rather than an educator.

7. Communities should organize to provide volunteer services for day care programs, residential programs and home care services.

8. Through bursaries, other financial assistance, and other means, young people of promise should be encouraged through governmental action to undertake training for service with the handicapped.

The lack of trained personnel in Alberta is grave.

9. Consideration should be given to the provision of residential and educational facilities for blind children in Alberta.

At the present time there is no resource in the Province. It would seem that at least two centres, one in southern and one in northern Alberta are indicated.

10. Immunization procedures against Rubella (German measles), which can be responsible for deafness and other anomalies in children, should be investigated, and, if feasible, should be employed in this Province.

11. It is recommended that facilities other than the Glenrose School Hospital be provided for children with cerebral palsy.

Such facilities would be less expensive than the Glenrose. More are needed because of increasing incidence.

12. Anti-convulsant medication should be provided for epileptic children without charge by the Government.

    Many other groups, i.e., arthritic, rheumatic fever, P.K.U., and others, are currently receiving free medication.

13. Immunization against viral meningitis, notably Ruboela (red measles) meningoencephalitis should be universally encouraged in the Province.

14. Continued action to stamp out tuberculosis in Alberta should be pursued.

15. While mass screening to discover anomalies of metabolic disorders is to be encouraged, the present state of knowledge in this regard does not seem to warrant mandatory screening of infants. It would probably be more effective to screen pregnant women. Research on the metabolic disorders of pregnant women is therefore to be encouraged.

16. Training programs for trainable mentally retarded individuals, now operated by the Alberta Association of Mentally Retarded, should be made the responsibility of the Department of Education and should be implemented by local school boards.

    The Association has carried on valiantly for over a decade in providing educational facilities at the local level. That function properly belongs to the Department of Education.

17. The Study Group recommends very strongly that (a) the facilities for mentally retarded at Red Deer should not be enlarged and (b) they should not be duplicated in other centres in the Province.

    A non-hospital facility for the care of seriously retarded individuals is much more effective and more economical and should be provided at the regional level. The large Red Deer hospital installations should be phased out or assigned other roles.

18. It is recommended that programs for educable mentally retarded children be geared open-endedly from the pre-school level to the secondary school level, with enough flexibility for transition to a variety of programs.

19. Pre-school age groupings are recommended to local and central authorities, both for diagnosis and for early socialization of the retarded child. Continuous programs are essential for the optimal development of these children.

20. At the local level, counselling services should be available to parents and to families of retarded children on a continuous basis as soon as a diagnosis of mental retardation has been affirmed.

    These services are intended to be supportive and informative; supportive to the family during periods of exceptional stress and instructional in pointing out to parents facilities and available resources. Such counselling services could be part of a guidance clinic, health unit, or any other suitable agency. Any costs for such services to indigent families should be borne by the Government.

21. At the secondary school level, particular emphasis must be placed on providing work experience. In the transition from school to full-time employment, a community agency should be available to assist in the guidance and placement of these young people.

22. It is strongly recommended that legislation be implemented to permit mentally retarded students to remain in school, under the responsibility of the Government, until age 21.

To cut off the responsibility of the Department of Education to these children at age 16 is most unrealistic in view of their slow learning rate and their restricted range of employability.

23. It is recommended that the Provincial Government take the lead in providing employment for mentally retarded persons in Government installations throughout the Province to the limit of feasibility.

The problem of employability of adults was not directly of concern. However, the committee felt that the employability of the mentally retarded is of importance in designing his training program, in assisting him to self development and esteem and to community acceptance.

24. In view of the large number of students of borderline intelligence and the potential loss of human talent, as they experience failure and frustration and develop aberrant behavior, it is strongly recommended that:

    a. Greater diversity of programs and flexibility of standards be characteristic of the Alberta public school curriculum at all levels.

    b. Individualized instruction and individualized promotion become more pronounced.

    c. Teaching techniques known to facilitate learning among slow students be given greater emphasis.

    d. School systems, wherever possible, be assisted to employ auxiliary personnel (psychologists, reading specialists) to assist with special programs.

    e. The Department of Education provide these specialists on a consultant basis, to school systems unable to provide their own.

    f. Special preschool and language-development programs be established in areas where a high proportion of the population is bilingual or New Canadian, with financial and other assistance from the Provincial Government.

g. Special junior and senior high school pre-employment and work experience programs be developed, to assist less able youngsters to become gainfully employed, self-respecting citizens. Liaison between educators and outside school agencies is essential.

h. Access to a high school diploma, via satisfactory achievement in "modified" vocational courses, be made possible for those students who wish to work toward that goal.

i. As a final recommendation, the Study Group strongly recommends that some independent body be appointed periodically to evaluate and report upon the implementation of these recommendations.

Conclusion

The present survey brought the members of the Study Group into direct contact with interested persons all over the Province. Cooperation at all levels and the knowledge and competence revealed were noteworthy. The excellence of physical plants and installations throughout the Province was impressive. However, the Study Group was dismayed by the dearth of staff at all levels to implement the programs which local people recognize as necessary. The most pressing needs have been described. The need for continued, intensive investigation of the problems must be apparent.

CHAPTER 14

MENTAL HEALTH SERVICES AT UNIVERSITIES[1]

Chapter 6 dealt in detail with "pupil services" in the public schools of the Province. The present Chapter is intended to remind readers that mental health problems do not disappear at higher levels of education and to focus some attention on one segment of the post-secondary school population. Other segments of that population, represented in part by the vocational schools and junior colleges, also require consideration by responsible Provincial and local authorities.

Dr. J.D.M. Griffin, Executive Director of the Canadian Mental Health Association, made the following remarks at a Conference on Student Mental Health held at Queen's University in 1963:

> "Perhaps most important, university educators have come to realize that unless something is radically wrong with the criteria by which university admissions are conducted, there can be no satisfactory explanation as to why the failure and drop-out rates are so high, unless the solution lies in the area of efforts to maintain the best possible mental hygiene among students. Just as it has been recognized in other societies that the prevalence of malnutrition or tuberculosis among students can hamper all the efforts of the educator, so it is now clear that mental health programming at the university is also a basic task of the modern educator."

At the same conference Dr. D.L. Farnsworth commented:

> "Some say that we cannot afford to give attention to the individual problems of students; I would maintain that we cannot afford not to. If we do not deal with the increasingly complex problems that students face, we will abet the development of factors that have a deleterious effect upon the process of education."

The Study Group supports the remarks of Drs. Griffin and Farnsworth in the light of their own experience and familiarity with available research. In summary, they reported that certain psychological and social influences impair the development and functioning of a significant percentage of university students.

Studies conducted in the United States, Great Britain and Alberta are in general agreement that 10 to 15 percent of university students have emotional disturbances or incapacitating symptoms of sufficient severity to interfere seriously with their performance. Another 10 to 15 percent of the students are mildly to moderately troubled and would benefit from professional help, but their functioning is not seriously impaired. (Farnsworth, 1957, 1964; Mueller, 1966; Paulsen, 1964; Sinclair-Gieben, 1961; International Universities Bureau, 1958).

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[1] A shortened and modified version of a report titled "Mental Health Problems of University Students" prepared by a Study Group under the chairmanship of Dr. C.M. Christensen, then Director of Student Counselling Services, University of Calgary, with Prof. A.J.B. Hough of the University of Alberta and Dr. S.A. Perkins of the University of Lethbridge as members.

Paulsen (1964) has estimated the frequency of emotional problems among university students as follows:

> 8 to 12% "of the students are severely troubled and will endure marked complications in function during their college period".
>
> 10 to 15% "are mildly to moderately troubled, but without serious impairment in functions".
>
> 20% "could benefit from professional contact, if only for an hour or two".

Although no systematic surveys have been made in Alberta to determine the frequency and types of problems, the Student Counselling Services have collected some information on students who request assistance. The results are in accord with those reported by Farnsworth and Paulsen.

At the University of Calgary, for example, approximately 20 percent of regularly enrolled students contacted the Student Counselling Services in one year. About one-half of that number displayed symptoms, of a psycho-social nature, which interfered with their satisfactory social and academic progress. Approximately 40% of students, who come to Counselling Services, are referred for psychiatric consultation. It is also certain that some disturbed students do not obtain professional help at the University and others obtain aid elsewhere.

Although the university environment is not free from pressures, which lead to maladaptive behavior, much of that which emerges is considered of pre-enrolment origin. The implication is that appropriate attention at an earlier age, in elementary and secondary schools, quite possibly would prepare students to cope more effectively with the university environment. In the interests of preparation and prevention, therefore, psychological services and other pupil services at the elementary and secondary school levels require more attention and emphasis. However, the mental health problems of today's university students cannot be ignored if valuable talent is to be developed fully.

Farnsworth (1964) points out that "clear evidence of disturbance will appear, if they are ignored, in the form of: dropping out, academic failure, plagiarism, stealing, excessive drinking, vandalism, and inappropriate sexual behavior."

Sanford (1968) has pointed to the need to examine critically the university environment and its possible precipitation of emotional problems. Without doubt the university places many new demands on students. Most come adequately equipped in terms of abilities, attitudes, interests and personality to handle the challenges and stresses. A relatively small minority are not in that enviable position but are able to meet the standards for admission. If they are to develop in accord with their potentialities they require some assistance.

Counselling services, required by universities to give help where it is needed, should include the following staff: counselling and clinical psychologists, social workers and specialist advisors in the areas of reading and study skills. In addition, an adequate student health service should be available. Psychiatric consultation should be provided as required, by either the health or the counselling service. The two services must have a close working relationship to facilitate inter-service referrals and maximum effectiveness of each. Joint meetings, particularly case conferences, would help maintain a productive relationship.

RECOMMENDATIONS

1. Universities should maintain adequate, interrelated health and counselling services, including ready access to psychiatric consultation in either case. Adequacy in the case of counselling services, the subject of this Chapter, should be determined in relation to:

    a. Reasonable demands for highly specialized services, not simply information and advice, which academic departments and advisors, and other non-academic officers and departments, should be expected to provide;

    b. The necessity to maintain working conditions, which will attract the highly qualified staff, who are able to provide the specialized services. Reference is made here to an academic role through joint appointments and an opportunity for research or professional development.

    c. The need for on-going operational research within the counselling service, aimed at evaluating its effectiveness and giving direction to its development.

    d. The need for continuous, time-consuming liaison between the service and other staff concerned with student welfare and development.

2. Further to 1(b) above, if universities establish departments or institutes of applied behavioral science, consideration should be given to the incorporation of counselling services.

3. Universities should encourage and support the type of research named in 1(c). It will be clear from this presentation that more information is required about the incidence and nature of emotional disturbances and maladaptive behavior among university students and about the stresses of the university environment, to permit systematic planning of remedial and preventive measures within a university's responsibility, including the provision of adequate staff.

4. More emphasis and resources should be assigned to prevention, early detection and treatment of maladaptive behavior and emotional disturbance by responsible agencies outside the universities.

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CHAPTER 15

THE ELDERLY

Section 1:	Mental Health and the Elderly by Prof. A.E.D. Schonfield
Section 2:	Brief of Alberta Council on Aging
Section 3:	Comment from Alberta Mental Health Study

"CAST ME NOT OFF IN THE TIME OF OLD AGE;
FORSAKE ME NOT WHEN MY STRENGTH FAILETH."

Psalms, 71

SECTION 1 MENTAL HEALTH AND THE ELDERLY

I INTRODUCTION

The Director of the Alberta Mental Health Study invited me in late August, 1968 to carry out a survey and submit a research paper on aspects of aging relevant to the Study. Unfortunately, the present submission cannot be considered an adequate answer to this request. The complex problems, the collation and evaluation of statistics, the gleaning of advice from many consecrated and experienced public servants in Alberta, all demand much more time than has been available. It has not proved possible to do more than scratch at the surface of different viewpoints, interests and conflicts. The most valuable outcome of this report could be its function as a stimulus for a more thorough investigation with a more adequate statistical basis for recommendations.

Having seen something of the work of those who labor on behalf of the elderly, especially the elderly sick, in Alberta, it seems almost presumptuous to comment on their devotion to those in their care. Often in extremely trying circumstances without the benefit of facilities which a younger generation takes for granted, much has been accomplished. Suggestions for future improvements imply an appreciation of the baseline from which improvements can commence, due to the efforts of past and present staff.

II LIMITATIONS OF EXISTING STATISTICAL DATA

The Dominion Bureau of Statistics and various departments of the Provincial Government request, obtain and publish statistical summaries of information from institutions in the Province. However, the lack of consistency in the categorization of data often makes it difficult to draw well-founded conclusions. Sometimes provincial breakdowns are not presented, and sometimes the Alberta figures are part of a Prairie Provinces conglomeration. Age distributions are usually given by decades, but occasionally an age group such as that from 25 to 44 is compared to the over 60's. Further, much of the data is based on 1961 census figures, and the increase in population since then makes the earlier information somewhat suspect. The difficulty in discovering facts can be illustrated by the absence of published information about the length of confinement of residents in Alberta Mental Hospitals. The gaps in tables and graphs presented in the present document are not, therefore, due to careful selection in order to strengthen arguments, but are the result of utilizing information which happens to be readily available.

A word of caution in the interpretation of statistical information, and the prevailing tendency to equate numerical figures with science, would not be out of place. _Ex post facto_ deductions can always be explained on the basis of more than one hypothesis, and the obvious or first conclusion may be unwarranted. For example, over the last few years the number of patients released from mental hospitals has increased, and it might be thought that this was solely due to improved therapy and changed outlooks among psychiatrists. However, a Calgary physician informed me that he had had the experience of patients returning from Alberta mental hospitals before they were, in his opinion, ready to do so. As a result, he attempts to obtain beds for his elderly mentally disturbed patients in auxiliary hospitals to obviate this difficulty. This implied support for Disraeli's dictum that there are three kinds of lies - lies, damn lies and statistics - does not mean that statistics are valueless. They are invaluable as a first step, and it is important that those who toil to provide them realize that they will be used with caution, but used.

The question of what statistics are needed, and which are perhaps superfluous, requires careful attention. This is an area where centralization may be preferred, since coordination can prevent duplication. It is therefore suggested that a senior member of the Mental Health staff of the Department of Public Health consult with the Hospitals Division of the Ministry, the Provincial Statistician, the Ministry of Welfare, the Dominion Bureau of Statistics, the Superintendent and Matrons of the hospitals, as well as interested research workers, on the question of data collection and publication (see also (7))*.

III SERVICES FOR THE ELDERLY AND THEIR COST

For present purposes aging can be characterized as associated with an increase in probability of requiring individual help from others in order to survive and to adjust to the environment. Of course, it is not only the elderly who need such help, and many older people are as

*Numbers in parentheses refer to publications listed on p. 28.

independent as the young. However, the likelihood of the presence of such needs becomes greater with age. The reason why the need for help increases is primarily because of biological and psychological age-related changes, but it is also due to a loss of socially approved roles and economic hardships. The extent and nature of these needs ought to be compared with the extent and nature of services offered in Alberta, so that an overview of the general mental health of the elderly can be obtained. For it is clear that nothing is more frustrating, and therefore injurious to mental health, than unfilled basic needs. Any exact comparison between needs and services, however, must be considered an impossible task at present. In place of this, the emphasis will be on attempting to assess how far facilities appear to be fulfilling their declared aims.

Modern industrialized societies meet the requirements of the aged in a variety of ways. The unbiased observer must surely conclude that on the average, public facilities offered to the elderly sick are vastly superior to those available in the past. The accepted aim is to provide a network of services and institutions with different functions. Some of the more important of such services offered in Alberta, with their reported costs are enumerated in Table 1. Alberta's emphasis has been on gradated services, with attempted differentiations between chronic and acute illnesses, between mental and physical illness, and between cases which require constant attention from registered nurses and those where the registered nurse occupies a supervisory role or where occasional home visits suffice. In most cases, the "user" pays a minimal amount and the brunt of the cost is born by public funds.

With one exception, the services provided by the various institutions listed in Table 1 are not confined to the aged, although the elderly constitute a much larger proportion of "users" than the proportion of the elderly in the population as a whole. This is exemplified in Table 2, where age distributions from census figures and those of "Service Users" are listed. It will be seen that the vast majority of recipients are over 60 years old. This table supports the earlier argument that with age special needs tend to increase.

There are some facilities financed from public funds where beneficiaries belong preponderantly to younger age groups - an obvious instance being education. Some other examples more relevant to mental

TABLE 1

EXAMPLES OF ALBERTA FACILITIES AND ESTIMATED COST PER DAY

		COST TO:	
Facility	"User"	Public Funds	Patient
Mental Hospitals (3), (15)	Acute & Chronic	$4.97 - 9.46	$2.00
General Hospitals (4)	Acute	$32.99 - 101.19 (over 200 beds)	$2.50
Psychiatric Wards of General Hospitals	Acute		
Auxiliary Hospitals (4)	Chronic	$11.30 - 44.63	$2.00
Nursing Homes (6)	Chronic	$7.50	$3.00
Senior Citizen Homes: Lodges (15)	"Well Aged"	($0.03 in Calgary, 1967)	$2.50 ($70.00-77.50/month)
Victorian Order of Nurses (15)	Acute	$3.82 (per visit in Calgary)	According to means

TABLE 2

EXAMPLES OF FACILITY USERS OR BED CAPACITY:

PERCENTAGE AGE DISTRIBUTION

FACILITY	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+	Total Number Users
Mental Hospitals (15) Ponoka, 1968	--	3.92	8.50	9.06	17.18	19.77	21.10	12.32	5.05	0.93	1,071
(15) Claresholm, 1968	--	--	--	2.16	8.40	27.82	35.25	18.23	7.67	0.48	417
General Hospitals (Including Psychiatric Wards), 1967 (15)	14.2	8.7	6.6 (Ages 20-24)	10.5 (Ages 25-34)	10.7 (Ages 35-44)	11.6 (Ages 45-54)	11.7 (Ages 55-64)	6.1 (Ages 65-69)	19.9 (Age 70+)		2,847,567 (Patient Days)
Auxiliary Hospitals, 1966 (4)	0.3	0.7	0.9	2.9	3.7	7.1	13.7	27.8	35.7	7.2	2,082
Nursing Homes, 1967 (6)	0.1	--	0.3	0.6	1.5	3.4	9.8	28.4	45.4	10.0	3,886
Senior Citizen Lodges (Calgary) 1968 (15)							27.73 (Ages 65-75)	56.74 (Ages 76-85)		15.53 (Age 85+)	779
Victorian Order of Nurses, 1968 (15)	4.01	1.34	2.34	2.67	6.34	5.67	13.67	29.34	31.01	3.67	300
General Population Alberta Census 1966 (10)	24.0	19.5	13.5	12.9	11.3	8.3	5.5	3.3	1.1	0.11	1,463,203

health are listed in Table 3. The decrease with age of incidence of mental deficiency is the result of shorter life expectancy, while the reduction in crime rates might be interpreted as due to an increase in wisdom. Guidance Clinic statistics are probably the outcome of a tradition that such facilities service the young.

It will be noted in Table 1 that charges to public funds vary greatly. At least part of the reason for this is that the costs quoted are not always comparable. Interest payments, capital depreciation, profit (for owners of private nursing homes), medical and drug expenses are included in some cases and omitted in others. Even within a specific grouping of institutions costs show gross fluctuations, as is demonstrated in Table 4 which gives a breakdown of some general hospital figures. The cost per patient day in a psychiatric ward of a general hospital is almost certainly less than the figures show, since a surgical patient will contribute disproportionately to an overall average hospital figure. Further, psychiatrists and others employed in the University of Alberta Hospital, Edmonton, and Foothills Hospital, Calgary, make very important medical contributions outside their specific duties in the hospitals, but the price of these is hidden in the bed costs.

Notwithstanding reservations about the reliability of the quoted figures, it is clear that it is impossible to divorce decisions concerning the best type of institution for answering the needs of the elderly from the costs involved. This must not be taken to imply that the cheapest is best; economic aspects cannot be the only consideration, nor yet the most important consideration, in our affluent society. In fact, a case could be made for increasing expenditures on those facilities which are operated very cheaply. It would nevertheless be unrealistic to recommend solutions to problems which necessitate, say, a sudden tenfold increase in Provincial Government expenditures on the mentally ill. The data presented in the tables also show that decisions concerning the distribution of government funds between different facilities are likely to have profound effects on the services offered to individuals. The location of a citizen's residence may perhaps determine whether he receives the equivalent of, say, $5,000 worth of care or $1,000 worth. It is also worth emphasizing that the costs of homes for the elderly and the provision of nursing services for older people in their own homes

TABLE 3

EXAMPLES OF SYMPTOMS DECREASING WITH AGE:

PERCENTAGE AGE DISTRIBUTION

	Below 20	20-29	30-39	40-49	50-59	60-69	70+	Total Numbers
Mental Deficients (Deerhome & Alberta School Hospital) (2) & (15)	39.26	20.79	11.99	12.17	9.15	5.30	1.36	2285
Alberta Criminal Offences (9)	29.82 (Below 20)	21.99 (Ages 20-24)	21.62 (Ages 25-34)	11.24 (Ages 35-44)	6.31 (Ages 45-54)	3.74 (Age 55+)		4508
Alberta Guidance Clinics (2)	86.8 (Below 20)	4.4	6.7 (Ages 31-50)		2.1 (Age 50+)			3975

APPROVED GENERAL HOSPITALS

SUMMARY - REVENUE FUND EXPENDITURE

TABLE 50: GROSS OPERATING COSTS BY TYPE OF EXPENDITURE, IN TOTAL AND PER ADULT AND CHILD PATIENT DAY (Food Per Meal Day)

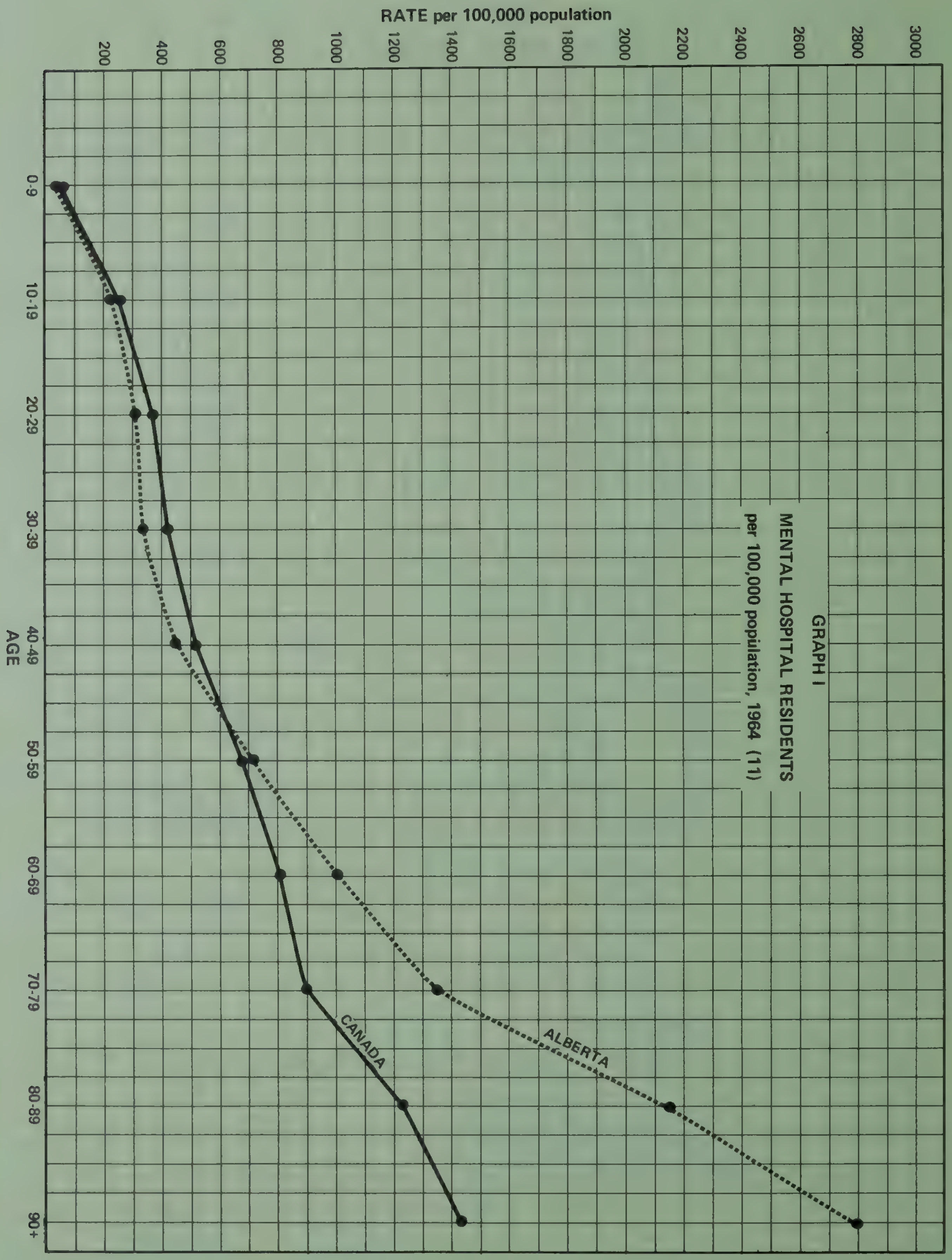
FOR THE YEAR ENDED DECEMBER 31st, 1966.

	Gross Salaries and Wages		Medical and Surgical Supplies		Drugs		Administration		Food		Laundry and Linen		Plant Operation, Maintenance & Housekeeping		Interest		Depreciation		All Other		Total	
HOSPITAL	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Meal Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day	Amount	Per Patient Day
200 - 499 BEDS																						
Calgary, Holy Cross	$ 2,840994	$ 26.17	$ 135024	$ 1.24	$ 150244	$ 1.38	$ 168862	$ 1.56	$ 191571	$ .92	$ 42448	$ .39	$ 128710	$ 1.19	$ 204666	$ 1.89	$ 896582	$ 8.26	$ 191356	$ 1.76	$ 4,950457	$ 45.61
Calgary, Foothills	1,393888	49.46	88844	3.15	30942	1.10	134498	4.77	107947	1.89	11811	.42	161229	5.72	822560	29.19	-	-	99616	3.54	2,851335	101.19
Edmonton, General	2,643648	23.14	142689	1.25	125833	1.10	146105	1.28	270250	1.22	42716	.37	228126	1.99	74853	.66	179065	1.57	173130	1.52	4,026415	35.25
Edmonton, Glenrose	1,766053	22.85	30166	.39	28266	.37	161333	2.09	261905	2.79	19073	.25	204608	2.65	184986	2.39	-	-	66356	.86	2,722746	35.24
Edmonton, Misericordia	2,247843	23.55	96164	1.01	150263	1.57	153031	1.60	169695	1.06	27235	.29	79445	.83	2229	.02	100512	1.05	129636	1.36	3,156053	33.06
Lethbridge, St. Michael's	1,217869	20.75	56636	.96	62458	1.06	65355	1.11	112041	1.07	12845	.22	152646	2.60	56032	.95	116818	1.99	84676	1.44	1,937376	32.99
Medicine Hat	1,411609	22.94	57760	.94	62531	1.02	80789	1.31	100081	.96	18195	.30	44971	.73	75099	1.22	147921	2.40	91562	1.49	2,090518	33.98
TOTAL	$13,521904	$ 24.86	$ 607283	$ 1.12	$ 610537	$ 1.13	$ 909973	$ 1.67	$1,213490	$ 1.28	$174323	$ .32	$ 999735	$ 1.84	$1,420425	$ 2.61	$ 1,440898	$ 2.65	$ 836332	$ 1.53	$ 21,734900	$ 39.96
500 BEDS AND OVER																						
Calgary, General	6,832884	23.02	319827	1.08	313596	1.06	396036	1.33	574124	1.10	57742	.19	246898	.83	291608	.98	325668	1.10	347969	1.17	9,706352	32.69
Edmonton, Royal Alexandra	6,229857	25.83	354468	1.47	352801	1.46	407570	1.69	573047	1.46	277344	1.15	410744	1.70	496964	2.06	276534	1.15	678688	2.81	10,058017	41.70
Edmonton, University	8,013203	26.38	505062	1.66	619913	2.04	449553	1.48	611248	1.17	91548	.30	342367	1.13	1,164179	3.83	247323	.81	774514	2.55	12,818910	42.19
TOTAL	$21,076944	$ 25.03	$1,179357	$ 1.40	$1,286310	$ 1.53	$1,253159	$ 1.49	$1,758419	1.23	$426634	$ .51	$1,000009	$ 1.19	$1,952751	$ 2.32	$ 849525	$ 1.01	$ 1,801171	$ 2.13	$32,583279	$ 38.70
GRAND TOTAL	$53,588688	$ 21.79	$2,515630	$ 1.02	$3,006470	$ 1.22	$3,482902	$ 1.42	$5,057804	$ 1.19	$ 920465	$ .37	$3,733297	$ 1.52	$4,290994	$ 1.74	$ 4,452051	$ 1.81	$ 3,963380	$ 1.61	$85,011681	$ 34.56

constitute a negligible expense in comparison with any kind of institution with organized medical fulltime services.

IV ALBERTA HOSPITALS, PONOKA AND EDMONTON

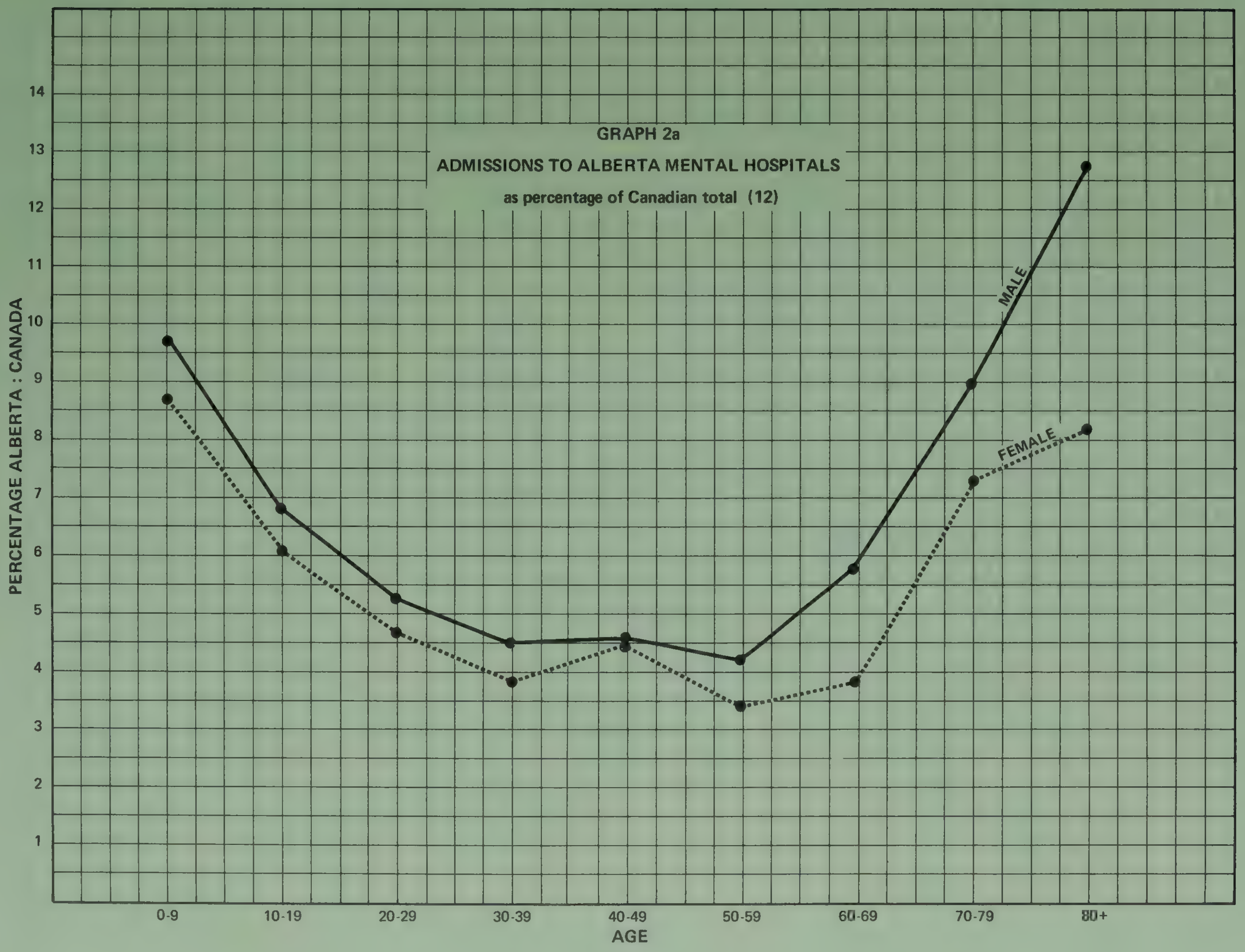
Because of the desire to provide gradated care in different institutions and also because of changed outlooks towards mental illness, the two large Alberta Mental Hospitals, each with approximately 1,000 beds, have come to be thought of as places for active treatment of acute disorders. In Alberta, as in the whole of Canada, admission and discharge rates have increased two to threefold since 1955, while length of stay in mental hospitals has decreased (7). Some elderly patients, however, may have improved sufficiently to be discharged from a mental hospital, but still require care and facilities unavailable elsewhere. Half-way houses, foster parents and sheltered workshops, which ease the transition from hospital to normal environments, are often unsuited for the elderly. For such patients, mental hospitals function more like an auxiliary hospital or nursing home. Graph 1 pictures the number of patients per 100,000 population in Alberta mental hospitals and those in Canada as a whole by age group. It is clear that till the age of 50, Alberta parallels the position elsewhere, but beyond that age there is a definite and increasing difference between the two curves. In other words, Alberta has proportionately more older people in mental hospitals than the rest of Canada. The basis for this difference is illustrated in graphs 2a and 2b. These graphs depict the proportion of admissions to and discharges from Alberta mental hospitals by age groups, as a percentage of the Canadian totals. Apart from the very young, discharge rates do not seem to vary significantly from Alberta's proportion of the general population (about 6% at the time). There is a drop in admission rates compared to Canada as a whole till the fifth decade, when more males begin to be admitted. The increase in female admissions begins in the 60's. In summary, more older people are admitted, while discharges remain constant. The reasons for the difference between Alberta and the average Canadian rate require further investigation, but one implication is obvious. Any recommendation to reduce the number of mental hospital beds must include consideration of the disposal of elderly patients.



GRAPH I

MENTAL HOSPITAL RESIDENTS

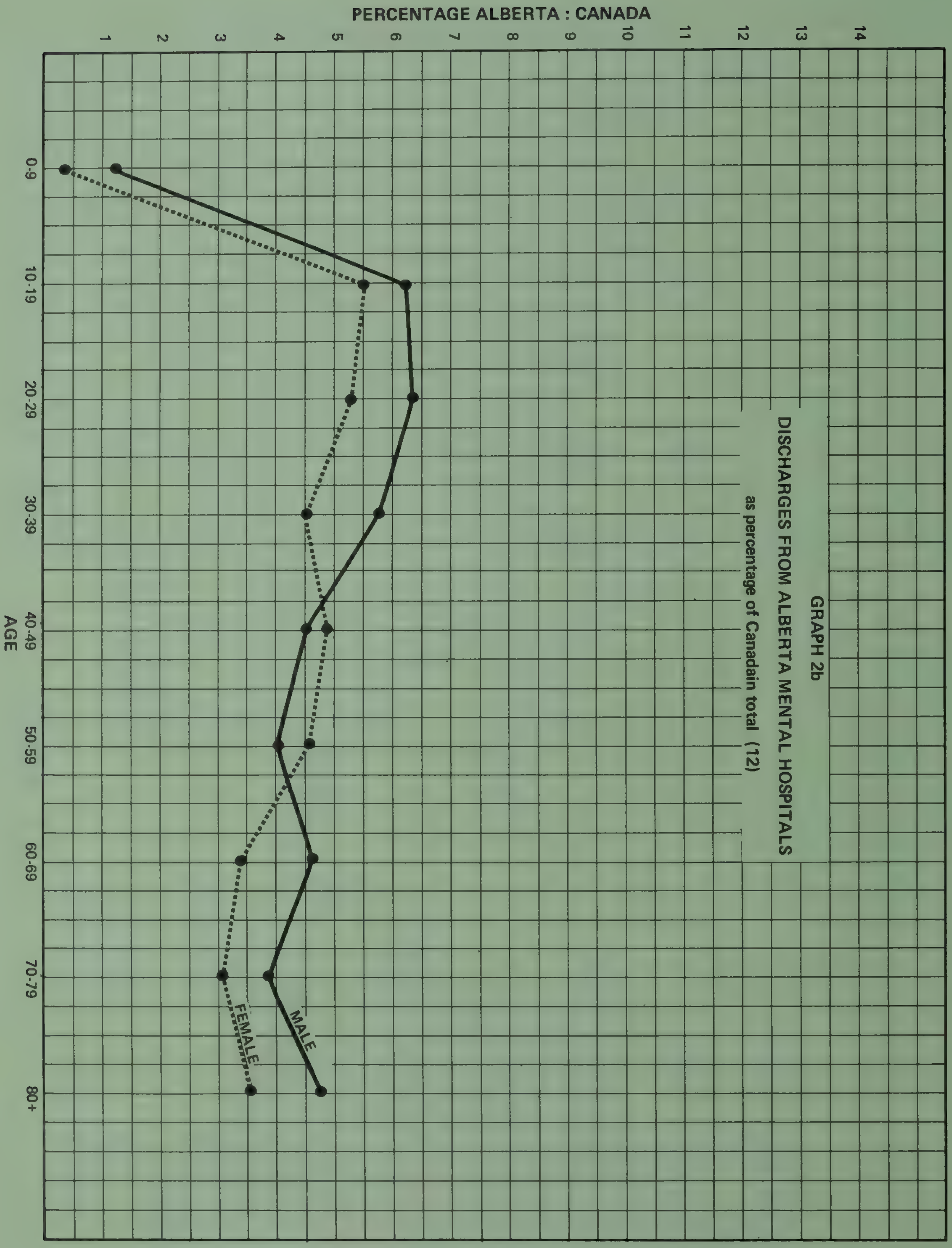
per 100,000 population, 1964 (11)



GRAPH 2a

ADMISSIONS TO ALBERTA MENTAL HOSPITALS

as percentage of Canadian total (12)



GRAPH 2b

DISCHARGES FROM ALBERTA MENTAL HOSPITALS

as percentage of Canadain total (12)

The suggestion that some elderly inmates do not need to be kept in mental hospitals raises the question of whether there are also some who should not have been committed in the first place. Perhaps gradated care for the elderly results in unnecessarily fine distinctions. The degree of confusion in elderly patients which requires exclusion from nursing homes or auxiliary hospital has not been, and cannot be, clearly demarcated. It will depend on the tolerance for aberrant behavior among the staff concerned, and this tolerance in turn depends on training, as well as resources available for psychiatric help. The point will be further elaborated in later sections, but again the implication is that decisions about number of beds for the elderly needed in mental hospitals cannot be separated from the provision of alternative facilities elsewhere. Even the type of elderly patient admitted to Alberta Hospitals will be affected by other facilities. One psychiatrist recently told me that his clinical impression was that the proportion of those seriously disturbed among recently admitted elderly patients had increased during the last year or so.

The location of the two hospitals and means of access through public and private transportation has particularly important implications for elderly patients. It has to be realized that the children of people aged 80 or over are themselves often elderly. For them, or even for those somewhat younger, a long drive or even a short drive on a difficult highway to the Alberta Hospital, Edmonton sometimes presents insuperable problems, preventing their visiting a parent. The building of a better road to the Alberta Hospital, Edmonton should be given some priority and the possibility of regular public transport facilities to both hospitals should be brought under consideration.

V ALBERTA HOSPITAL, CLARESHOLM, AND ROSEHAVEN, CAMROSE

These two hospitals, each with about 500 beds and a hundred patients per ward, are designated as chronic mental hospitals. With very few exceptions, patients are admitted only after they have spent some time at the Alberta Hospital in Ponoka or Edmonton. The director of the Mental Health Division of the Ministry acts as Medical Superintendent at both Claresholm and Rosehaven, while the matrons of the respective institutions are responsible for general supervision. However, there are important differences between the two hospitals. For example, admissions to Rosehaven are confined to those over 70 years old, while Claresholm caters for all age groups, although in fact some 60% of the patients are aged 60 or over. The ommission of the label Alberta Hospital from the title of Rosehaven is also worthy of note. It might be thought that a Rosehaven by any other name would smell just as sweet, but the social stigma for families that mother or father resides in a mental hospital is avoided by the change in nomenclature.

There seems to be a sufficient supply of untrained helpers at these institutions, but it is astonishing that no psychiatrist, social worker or psychologist has been allocated to the hospitals, and it is even more distressing to report that the total complement of certified nurses is about 15 in each hospital. (Medical services are available from local doctors, who do not appear to have any special qualifications in psychiatry, neurology or geriatrics.) This means that there are only two, or perhaps three people with any level of accepted training looking after 500 patients at night-time. Incontinence is the accepted way of life at Rosehaven, and patients able to control themselves may have to wait up to two hours before someone comes on regular rounds to help them to the bathroom. Mentally normal younger individuals would have difficulty in coping with such situations. Although it is pointless to allocate blame for this state of affairs, it is important when criticism is implied to ensure that those carrying out their duties in exemplary fashion do not suffer censure. I want, therefore, to pay personal tribute to the matrons of Claresholm and Rosehaven for the care they provide for their patients, and their example in displaying sympathetic attitudes, which their staff follow.

Many of the patients in these hospitals have no contact with family or friends. It is difficult to obtain facts concerning the number who receive visitors, but an estimate of 15% is probably high. Because the hospitals are far from large centers of population, visits by families will usually involve considerable sacrifices. The visit itself is likely to be heart-rending, and people will understandably manufacture rationalizations in order to avoid such painful experiences. The number of years which have been spent in mental hospitals will also affect contacts with the outside world. Once again, figures are not readily available, but it seemed as if quite a few patients have been incarcerated for over twenty years.

It would be unfair and wrong to leave the impression that administrators in Edmonton had overlooked or forgotten the needs of the patients in these two hospitals. Any visitor, however emotionally upset, quickly realizes that improvements in buildings and equipment, costing many millions of dollars are taking place. But overworked administrators have not the time necessary to weigh priorities with the required care, especially when the only pressures felt are from those lower down in a civil service hierarchy. For example, some patients' beds are still only two-and-a-half feet in width and these are being slowly replaced by more standard sizes. This is, of course, essential considering the dimensions of older people's bodies. The replacement, it is said, cannot be undertaken rapidly because of the expense involved - an expense which almost certainly does not exceed $10,000. This seems a pitiful example of saving taxpayers' money, especially in view of the costs of running other institutions as enumerated in Table 1. A little less emphasis on cost is desirable, so that more consideration can be given to questions such as: means by which some privacy is available in lavatories, enjoyment by elderly people of their bathing time rather than army-type bath/shower parades, hand rails on paths in the grounds of hospitals, short periods of exercise for patients who move infrequently, provision of furniture with space for storing personal belongings, originality in stimulating the desire to participate in occupational therapy, whether locked doors are really necessary and the desirability to avoid the use of prison-associated terms such as "parole," and so on.

A more difficult problem than those mentioned so far is the basis for deciding who should go to such hospitals. Decisions at present seem to be based on: (a) availability of beds; (b) chronicity of illness; (c) origin of patient in nearby geographical area. The number of beds available is determined by death of existing patients and construction of new buildings. Whether a particular mental illness should be labelled chronic is usually the result of past unsuccessful treatment, but psychiatry and psychology are renowned (or notorious) for new therapeutic interventions. And given the location of the hospitals, the likelihood of family or friends in the vicinity is extremely meager. The criteria which seem to be used at present for admitting patients to these hospitals lead to the general issue of the future of such institutions. It is difficult, perhaps impossible, to suggest acceptable solutions. One observation during my visits may highlight some of the problems involved. Not once did I notice an elderly patient talking to another patient during the hours that I spent at Claresholm or Rosehaven.

VI OTHER INSTITUTIONS ADMINISTERED BY MENTAL HEALTH DIVISION

The Alberta Hospital, Raymond, has about 50 patients, all elderly females. The Director of the Mental Health Division acts as Medical Superintendent and the hospital is administered by a matron. Although I did not have the opportunity to visit this hospital, comments made earlier about Claresholm and Rosehaven are probably equally relevant to Raymond.

Institutions for mental defectives have relatively few elderly patients and therefore do not present any special geriatric issues. Some confusion often results through amalgamating mental deficiency and mental illness statistics, and it would be helpful if in future these were separated.

VII PSYCHIATRIC WARDS OF GENERAL HOSPITALS

Responsibility for these wards, which in 1965 had a total of 138 beds, is in the hands of Hospital Boards and, indirectly, of the Hospitals Division of the Ministry. The number of elderly patients treated in such wards in Alberta is not known. The medical profession as a whole tends to favor a greater reliance in the future on this type of facility in preference to mental hospitals (5). Although some vested interests may influence this viewpoint, there are many good reasons for the recommendation. Perhaps the most important is the involvement of local communities in their own hospitals. One of the great dangers of the large, distant and isolated mental hospital is the tendency of physicians to lose their feeling of responsibility for individual patients moved there.

The costs involved (see Table 1), as well as the official function of these wards, make it impossible to consider using such facilities for the permanent care of many elderly patients. It is important therefore to establish whether elderly patients respond to the treatment offered. The answer to this question seems to depend on whether a psychiatrist attached to the relevant ward has concentrated on geriatrics. Unfortunately, few psychiatrists have specialized in this aspect of their discipline. But when such rare individuals are available, the number of elderly patients who show considerable improvement in these wards is far greater than many physicians, and for that matter many psychiatrists, suspect. In discussing the matter with experts, it is impossible to escape the impression that there is occasionally an unnecessary tendency to give up hope and to have recourse to certification too readily. Short periods of confusion, followed by a return to adequate contact with reality may be the rule rather than the exception for the elderly, given adequate medication. Much more is now being attempted in this sphere, especially in the wards at the Foothills Hospital, Calgary, and the University of Alberta Hospital, Edmonton.

VIII AUXILIARY HOSPITALS AND NURSING HOMES

These two types of institutions are ultimately answerable to the Hospitals Division of the Ministry of Public Health, since their primary concern is with physical ailments. Hospital Boards have acted as the immediate supervising authority of auxiliary hospitals, whereas nursing homes have been built by private enterprise or religious foundations and are directly subsidized by the Provincial Government. Recent statements by government spokesmen suggest a change in policy, with future nursing homes administered in the same fashion as auxiliary hospitals. From many points of view the failure of this experiment in cooperation between government and private enterprise is regrettable. Competition between nursing homes to give the best possible services to patients was a worthy aim. Unfortunately, the benefits of capitalist competition seem only to occur when potential supply is greatly in excess of demand. With long waiting lists for vacancies and minimal government inspection, some nursing homes have not developed the desired standards. On the other hand, the best nursing homes and the auxiliary hospitals operated by religious foundations are often said to provide far more personal and humane attention to patients, than the general run of auxiliary hospitals. The timing of the final meal early in the evening and the "open door" policy for lavatories are examples of lack of consideration in some of the latter institutions.

The differentiation between patients for whom nursing home care suffices and those where the facilities of an auxiliary hospital are required cannot always be reliably made. An even more difficult decision is the degree of mental confusion which justifies removal to a psychiatric type of institution. At the other extreme, some patients in nursing homes might be placed in senior citizens lodges, if more of these residences were available. A valuable recent survey by Dr. Crosbie and his colleagues (8) came to the conclusion that less than 10% of nursing home patients might be considered "misplaced." The report also stated that approximately 5% out of the 10% in this group of patients were sufficiently confused or uncooperative to present serious problems, but not so ill so as to require transfer to a mental hospital. In auxiliary hospitals some 35% of patients are said to suffer from diseases of the nervous system or neurosis, but none from psychosis (4). It seems, therefore, that there is a need for some specialization among the nursing homes in large cities, and perhaps also among or within auxiliary hospital services. Many advantages would accrue if a few nursing homes tended to concentrate on patients with minor mental disorders. The staff of such nursing homes might develop new skills through experience, become known for their tolerance of the aberrant patient and develop useful links with psychiatrists. Were this plan put into operation, financial support for the specialized nursing home would have to be negotiated on an individual basis. Fresh consideration might also be given to the question of building larger nursing homes. These allow a greater degree of potential specialization with difficulty of egress in some wards.

A recent innovation in Calgary has been an arrangement whereby nursing homes and auxiliary hospitals can consult with a psychiatrist who has specialized in geriatrics. A peripatetic nurse who has received a short training course is also available to the institutions. This type of liaison is clearly a large step in the right direction. The knowledge that outside medical help is at hand has indirect results in strengthening the self-confidence of staff, quite apart from the learning situations which the arrangement provides.

The increase in the number of older people in the population shows no sign of diminishing and waiting lists for nursing homes, as well as auxiliary hospitals, demonstrate the need for more of these facilities. Those who are waiting often occupy more costly beds in general hospitals.

As the size of the operation grows, there is a danger that too much power is concentrated in the hands of one administrator - however benevolent a dictator he may be. A greater adherence to rigid rules and a possible neglect of the welfare of some individual patients may also ensue. The length of time which a bed may remain unoccupied while a patient is removed to an active treatment institution, and even the decision to remove him, can easily become matters which the individual patient or his family cannot influence. Many precedents exist elsewhere where the size of an organization is correlated with neglect of the individual. When an individual's whole life is circumscribed by the few feet surrounding his bed, it is necessary to be constantly alert to the possible grave harm to mental health through unthinking acts by those who possess the best of intentions. Notwithstanding these criticisms and warnings, it is proper to echo the Prime Minister of Canada's praise of the Government of Alberta and its Ministry of Public Health for the imaginative way in which they have established auxiliary hospital and nursing services.

IX SERVICES IN PRIVATE HOMES

Various ways of providing for the needs of the elderly in their own homes have been discussed in a separate brief (1) and the case for greater emphasis on these types of services is made there. Welfare agencies and departments of all levels of government provide for facilities of this nature, but in limited amounts. Meals on Wheels, Home Makers/Help Services, pensions, financial assistance, public health nursing, are examples. The Victorian Order of Nurses is singled out for special comment because the Calgary branch is facing an economic crisis. This service is financed in large part by the United Fund. It now seems as if it will have to curtail its activities rather than expand them in accordance with increasing demands. The Provincial Government makes a small grant of approximately $15,000 to the provincial headquarters of VON, but this seems unduly parsimonious. In the welfare fields the Provincial Government underwrites 80% of costs of comparable activities under Preventive Social Service legislation. Home nursing of the type under consideration should be viewed as a major preventive facility and subsidized to a much greater extent than heretofor. It seems a terrible waste for senior VON personnel to have to spend their time soliciting for funds, instead of fulfilling their supervisory nursing roles and increasing contacts with physicians in general and psychiatrists in particular.

X HOMES FOR SENIOR CITIZENS

A recommendation to provide housing subsidies for needy older people is made in the Alberta Council on Aging Brief (1). The necessity for an expansion of existing programs for lodges and units is demonstrated by a waiting list of some 750 people in Edmonton and 290 in Calgary. (These figures should not be considered completely reliable since some of those who need accommodation do not request it, because they feel it is hopeless to do so, while some others probably pass away while on a waiting list of this size.) Existing figures suggest that some rural areas may be oversupplied with this type of accommodation. The five lodges in the Province where residents number less than 40 (out of a possible 50) are Sedgewick, Bow Island, Raymond, Claresholm and High Prairie (15).

Improving future lodges through adding more single rooms, and providing some kind of stimulating recreational facilities in existing lodges raises the question of the finances and administration of this program. Table 1 showed the success that has been achieved in organizing these homes on a ridiculously low budget. A more liberal attitude towards expenditure with the support of local taxes would permit the appointment of qualified consultant staff as a resource for matrons. Such specialists are needed if the homes are to develop imaginative facilities and become more lively than they are at present. Special consideration should also be paid to geographic locations of future homes, and public transport facilities, in particular on Sundays, available to existing homes. Geronters (16) enjoy visiting; reducing contact with families and friends, who themselves are often elderly, because transport is unavailable has detrimental effects on mental health.

XI POVERTY

Somerset Maugham summarized the problem of economic needs and their effects by saying "money is the sixth sense without which you cannot make the most of the other five." The relation between mental health and financial hardship would be difficult to document, but it can be taken as a given that poverty can prevent individuals from participating in activities and buying facilities necessary to maintain mental health. The relation between age and poverty is well established. Sixty percent of low income individuals were 55 or older in 1961 and nearly a third were over 70 (13. p. 121). In Alberta there are 91,590 people in receipt of old age security and approximately 50% of these receive guaranteed income supplements (15). The Provincial Government helps nearly 18,000 elderly people through its various public assistance programs, including many residents of nursing homes and auxiliary hospitals.

These figures point towards the fact that a large number of the elderly are not participating in the improved standards of living of other Albertans. There are probably over 60,000 old people who are attempting to subsist on a little over $100 a month. Facilities for the elderly, supported out of public funds should cease being considered as a welfare handout requiring increased taxation, but as a right. In a very important sense it is a privilege to contribute to the well being of the older Albertans.

XII INSTITUTIONALIZATION AND GENERAL ASPECTS OF AGING

Learned journals have recently paid considerable attention to the dangers of institutionalization and have even identified a group of symptoms as the "institutionalization syndrome." An important aspect of this problem seems to be that adherence to rules in the institutional setting becomes an end on its own for resident and staff alike. Patients easily develop a fear of any change in routines and show a passive recipient attitude. This tendencyis probably accentuated in the elderly, since, with age, there is in any case a greater reliance on habitual forms of behavior. For this very reason, elderly patients or residents in homes need to be stimulated by a certain amount of change. Some disengagement from youthful activities may be desirable, but complete disengagement constitutes preparation for death and not active living.

Research findings about institutionalization have many implications for mental health. The most obvious is that means of avoiding this form of care should be considered a major aim of public programs and projects.

No less obvious is the desirability of attempting to de-institutionalize the institutions that have to exist. Even if it takes longer and causes more bother for a patient to do things for himself or for herself, staff should resist their tendency to "save the patient trouble." There is much truth in the saying that kindness kills.

Drastic changes can also cause harm and even the expectation of change has been shown to result in acute stress in the elderly (14). Habits and rules are the necessary supportive background for coping with change. The best balance between amount of desirable change and reliance on habitual behavior will vary. As usual, the enemy of smooth running of organizations is individual differences, but staff should be trained to welcome this enemy and react appropriately. The institutionalization of staff is perhaps as great a danger as the institutionalization of patients. Actions which involve risks of something going wrong are often to be preferred to apparent gilt-edged security. Further, the tolerance of the patients for slight degrees of change provides a type of knowledge of results of the efforts of the staff. One reason for the unpopularity of nursing the elderly sick is the absence of signs of improvement. Any kind of measure of change counteracts this and hospital records of such changes have a reinforcing function. Even a reduction of soiling the bed from every night to once a week, or perhaps six times a week, is a worthy aim and results should be noted. Change or labor turn-over of staff is relevant in this context. Although need for some permanence in staffing arrangements is desirable, staff and patients alike will benefit from the infusion of new personnel who can be expected to introduce different viewpoints and attitudes.

The institutionalization of staff can also be considered as equivalent to a tendency to stereotyping. When we refer to "the aged," "the elderly" or "them" we are indulging in a form of prejudice, to which older people understandably object. Many of the elderly dislike mixing with people of their own age group, possibly because they do not want to be labelled as "another oldster." The tendency to stereotype comes to the fore in the attitude of some staff towards complaints. Older people complain more, it is said, and therefore the problems they raise can be ignored. There is little evidence that the aged in fact do voice complaints more often than the young, but it is certainly untrue that when they complain there is necessarily nothing to complain about. A similar type of fallacy occurs among more sophisticated professionals in discussions of depression. There is good evidence to show that the incidence of depression is greater among the aged, but this does not imply that a measure of average depression level is higher in the normal aged. More older people may suffer from depressions, although those who do not may be less depressed than "normal." Geronting (16), as it has been termed elsewhere, should be the expected way of life.

Some of the conclusions to be drawn from this cursory discussion are: (a) the requirement of a greater emphasis on record keeping; (b) the desirability of short training courses for staff working with the aged at any level; (c) the need for more staff so that time is available for stimulating individual patients.

XIII DECISION MAKING PROCESSES AND SOME ADMINISTRATIVE PROBLEMS

Western democracies have espoused two opposing views on the most efficient methods of controlling government expenditure. On the one hand, there are those who want decision making, and its justification to be as public as possible. On the other hand, there are many who wish to allow senior civil servants or the minister to be complete masters in their own homes, with dismissal as the threatened sanction against incompetence. Open discussions tend to be favored in the United States, private decisions with only occasional parliamentary questioning has been the traditional British way. The compromise solution, which attempts to obtain the benefits of both methods, has been the formation of representative advisory committees consisting of members not mainly representative of the vested interests involved. The Government of Alberta has established a number of councils of this nature, the Universities Commission being a recent example. Their functions vary, while their relationships with the executive and legislative branches of government cover the range from almost complete autonomy to almost complete dependence. In the mental health field there is already a Board of Visitors, but its powers and the pressures it can exert seem minimal. An advisory council, with both lay and professional representation, to plan future developments in the mental health field seems a desirable aim.

The drawbacks of having too much power in the hands of one or two individuals are well known. It has been rightly said that "power corrupts and absolute power corrupts absolutely." It should also be recognized that the Minister himself, as well as his senior civil servants, is under pressure to economize. As a result, he probably does not have the number of senior staff needed to allow him, or the public servants involved, the time required for sufficient consideration of the multitude of issues involved in the mental health field. An advisory council might be of help in justifying an increase in senior staff in the Ministry itself. Although membership of the Council would not be anything like a fulltime occupation, the people concerned could be expected to develop a depth of knowledge necessary to add weight to their recommendations. The annual parliamentary debate on all health estimates, especially in a legislature with a large majority government, does not encourage individual members to acquire the knowledge needed to have an overview of the total Alberta mental health situation, or to criticize details. This would not be true of an advisory council.

XIV CONCLUSIONS AND MAJOR SUGGESTIONS

Numerous recommendations are scattered throughout this report, and these are summarized on the final page. They are not repeated in this present section which is confined to a few major issues.

(a) Organization. Having given some thought to Alberta mental health problems, I have come to realize that most of the more obvious solutions have important drawbacks. A proposal to close down a mental hospital implies that millions of dollars of public money must be considered as wasted. This kind of recommendation is not to be made lightly. The Mental Health Study will be in a far better position to weigh pros and cons, but even it is limited by time pressures. What is required therefore is a permanent mental health study group. Admittedly the terms of reference of such a group will raise all kinds of difficulties, but these are not insurmountable, provided that the Minister and his staff view the proposal with favor. Should the suggestion be unacceptable, the Human Resources Development Council might consider the establishment of some alternative body with the same type of function.

Problems of administration at local levels have received insufficient emphasis in this report and deserve more consideration. The kind of independent advisory board which has been suggested, might well decide this to be the first area to which it should give attention. And the Minister might welcome such a decision.

(b) Staffing. In my opinion, there can be no question that a reconsideration of staffing needs warrants receiving the label "first priority." The assessment of needs should be linked with a plan to meet them. Such a plan would undoubtedly include the provision of special emoluments to attract professional staff to outlying districts and the appointment of consultants in various specialties to advise staff and train helpers.

It is important to avoid the kind of over-professionalization which excludes potential workers from the areas under discussion, because they lack long years of university education. There is good evidence that a large untapped supply of people with the necessary personal qualities exists. They could make invaluable contributions after attending short training courses, culminating perhaps in some form of certification. Government sponsored courses should be offered not only at universities, but also at less populated centers in a variety of aspects of psychiatry, gerontology, sociology, etc. Such courses should be open to those working or intending to work in mental hospitals, as well as those employed in nursing homes, auxiliary hospitals and senior citizen lodges. These courses would be expected to upgrade the level of services offered in a short period of time.

The appointment of a suitable psychiatrist to spend at least two days a week both at Claresholm and Rosehaven might have far-reaching effects on some of the patients in these institutions. A special allowance of something like $200 a month to attract adequately trained nurses to these hospitals would be a negligible expenditure in comparison to potential benefits. The appointment of a consultant occupational therapist to stimulate and train aides in the various institutions is clearly desirable.

A special effort should be made to subsidize a few psychiatrists in different parts of the Province to take advanced training in geriatrics. The presence of such experts is likely to be of the greatest benefit to other physicians and professionals working with older people. The appointment of consultant occupational therapists to advise nursing homes and auxiliary hospitals throughout the Province is also recommended. Similar types of appointments of social workers, recreational experts or psychologists are suggested for Senior Citizens Homes and the Golden Age Clubs.

The backbone of most of the services discussed in this report are nurses and nursing aides. A careful survey of future nursing requirements would surely suggest that there is an urgent need for increasing the number of nurses in training at all levels. The problem has to be faced, however, that many nurses prefer not to work with geriatric patients. This itself requires investigation, with the aim of suggesting ways by which such duties can become more desirable.

(c) Research. The present report has placed the major emphasis on services. This is at variance to recent apparent trends of society in general, and universities in particular, which upgrade research to the detriment of other activities. At its best, research does not divorce itself from practice. The halo effect of research can usefully spread itself to stimulate interest in newly established professions and disciplines. A priming of research pumps in the fields of psychiatry and psychology is likely to increase the supply of personnel with knowledge of, and interest in, working with older people. The research workers themselves are necessary for the provision of educational courses suggested earlier. The Alberta Council on Aging has made specific recommendations for a Center of Gerontology in one of the Provincial universities (1). This type of Institute should not be thought of as diminishing the monies available for services or programs, but a necessary adjunct to them.

(d) Voluntary Work. Governments cannot provide for all the needs of the elderly sick and they should, in any case, be the object of loving care. Visiting of patients in Claresholm and Rosehaven could be a project undertaken not only by established service clubs in other parts of the Province, but also of university students. The new University at Lethbridge might consider the possibility of "adopting" the Alberta Hospital, Claresholm. What is required is not an invasion by hundreds of boisterous students, but one or two individuals committing themselves to some general responsibility for one patient. Inexpensive jewellery, reasonable clothes, books and Christmas presents would all be welcome. It is however, the visiting itself which, in the long run, might prove most valuable, but would entail real sacrifices.

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BRIEF ON ALBERTA COUNCIL ON AGING

PREAMBLE

HISTORY OF ALBERTA COUNCIL ON AGING AND PURPOSE OF BRIEF

Problems associated with aging processes have become of increasing concern to practitioners of medical and social sciences, research workers and legislative bodies during the second half of the 20th century. This concern with the great numbers of people in the older segment of the population led to the appointment of the Special Committee of the Canadian Senate in 1964 and the calling of the first Canadian Conference on Aging in 1966. The Alberta participants at that conference decided that there was an urgent need in the Province for an organization which would promote social action in helping to alleviate the problems of the aged and the aging. The Alberta Council on Aging was founded with this aim and incorporated under the Companies Act in 1967.

The stated objectives of the Council are:

1. To define the needs of the aging and the aged and to bring current needs to the attention of the appropriate governmental or voluntary agency for subsequent action.

2. To encourage systematic compilation of information on the situations facing the aging and the aged in the Province of Alberta.

3. To develop public discussion about the processes of aging and their social implications.

4. To mobilize leadership and identify resources in Alberta to meet the needs of the aging.

5. To encourage study of existing, proposed and needed legislation at the municipal, provincial and national levels which is, or may be, concerned with aging.

6. To encourage research and to disseminate significant findings.

7. To foster inter-agency liaison and cooperation and to act as a ways and means committee to achieve the aforementioned objectives.

These objectives are given in general terms and problems of mental health, although not specifically mentioned, are implicity covered in every section. The emotional, physical, social and economic well-being of the aged cannot be separated, for each affects the others and mental health is a function of all of them. The present brief, therefore, attempts to bring into sharper focus the more important requirements for improved mental health. With regard to some of these requirements the Alberta Council on Aging has initiated proposals or given its support to the proposals of other groups. The establishment of the Alberta Mental Health Study encourages the Council to hope that more will be accomplished in these areas in the near future.

PRINCIPLES AND GUIDELINES

POSITIVE EMPHASES OF MENTAL HEALTH

Since ill health and distress tend to be more conspicuous than their absence, there is a danger that the need for facilities for the seriously sick overshadow the requirements of healthy older people. The vast majority of people beyond the age of 65 are not in institutions, nor in hospitals and can continue to live full lives in their own homes, if a network of community services is available. Greater emphasis should therefore be placed on the positive features of the later years of life and the prevention of deteriorating processes before the stage is reached where institutionalization constitutes the sole solution to an older person's problems. To be master or mistress of a personal castle - however small - , and to plan one's own activities are important components of mental health and make for better attitudes towards old age. The Council therefore supports schemes or proposed services for older people in their own homes, which ameliorate their difficulties and obviate the need for institutionalization.

ECONOMICS AND WELFARE

Present day emphasis on gross national product and the individual worker's productivity creates a danger of substituting means for ends. Increased productivity of itself has no value; it is increased consumption which acts as the barometer of improved standards of living. Whether old people are producing more or less, working or not, they too have the right to share in the increasing resources available to the community at large. Material needs have to be assessed on a relative basis and facilities which might have been considered adequate 50, or even 20, years ago constitute poverty levels in today's affluent society. When such needs are not met, frustration and hopelessness with their concomitant emotional and physical upsets occur. In the case of the aged, such frustrations are of course confounded by other problems, and, as is well known, frustration effects constitute geometric progressions. It is the view of the council that adequate financial provision is necessary for mental health. The moral fibre of a society, it has been said, can be judged by the treatment given to its older citizens. Therefore, pension scales, health services, provision of housing, and transport facilities must be kept under constant review in order to ensure that the older segment of the population shares in the improved standard of living of the community as a whole.

THE WHOLE PERSON

Textbooks and professional workers constantly emphasize the importance of treating, helping or merely being aware of the whole person. With the growth of specialization, this is often an unrealistic aim and may not always be in the best interest of client or patient. What is being emphasized therefore is that although many facets of an individual can be separated conceptually, they are usually inter-related. With age, these inter-relationships become even more pronounced, multiple causes and multiple effects of a biological, social and psychological nature being the rule. Narrow specialization within gerontology is likely to hide the importance of such inter-relationships with detrimental effects to solutions of problems of aging. The Council therefore encourages a multi-disciplinary approach to training of field practitioners and places special value on research projects with applied implications.

AGING AS A CONTINUOUS PROCESS

North American society and culture display many signs of youth orientation. This, of itself, does not justify criticism, but unfortunately there is an accompanying denigration of old age. "Why grow old" is the common motif of too many advertisements. The advertisements merely mirror much of society's attitude toward aging as if it were some shameful disease, and towards the aged as if they were an unfortunate minority group. The important point that is forgotten - and this itself may constitute a kind of defense mechanism - is that unlike any other minority group, this is one to which all of us eventually wish to belong. Moreover, the expectation that the later years of life are likely to be devoid of happiness and a time of tribulation creates unnecessary fears with detrimental mental health effects on young and old alike. Expectation of unhappiness is probably the best guarantee of its occurrence. The best guarantee against its occurrence is adequate preparation. In a somewhat similar fashion to the way in which we learn to be adults during our childhood, so also we must learn to become old during our youth and adulthood. This implies a reduction, rather than an increase, in barriers between generations, and a knowledge of the kinds of adult activities which may help or hinder later contentment and good health. The Council encourages the view that aging should be perceived as a continuous process, with the earlier years of life providing preparation for later health, recreation, social, economic and ethical or spiritual needs.

NEEDS AND RECOMMENDATIONS

(A) MEETING NEEDS TO REMOVE DEFICIENCIES

Many programmes are operating in different parts of the world with the aim of providing in private homes those facilities previously only available in hospitals or institutions. The financial burden on the community of such programmes has often been shown to be considerably less than moving all of the people serviced out of their homes or apartments into an institution or public home for the aged. More important than the economic argument is the humane consideration of encouraging the elderly to remain independent, which in turn is beneficial to their mental health and physical well-being. In Alberta, a start has been made with such facilities, for instance Meals on Wheels in Calgary, but much more needs to be done.

(1) Home Care Programme

Some elderly patients require a range of services (such as medical, nursing, social work, housekeeping, nutrition, physiotherapy) for adequate care and rehabilitation. An organized home care programme provides and coordinates such services, so that the patient receives each of them in the amount he needs. The Victorian Order of Nurses proposed such a programme for Calgary in 1958 and 1963, presenting a brief to the Provincial Government and requesting the necessary financial support. The matter has also been discussed on a number of occasions at meetings of the Government Liaison Committee, which the Government of Alberta established to exchange information between cabinet ministers and the Alberta Council on Aging. The Victorian Order of Nurses is still willing to start a project of this nature. However, its funds are already over-stretched and full financial coverage is required before the programme can become a reality. It is to be expected that many difficulties will be met during the first stages, and later programmes will benefit from the experiences encountered. The proposal therefore can be considered to be in the nature of a research project.

IT IS RECOMMENDED THAT THE SUM OF $90,000 BE ALLOCATED OUT OF PUBLIC HEALTH FUNDS TO THE VICTORIAN ORDER OF NURSES FOR THE INITIATION OF A PILOT PROGRAMME OF ORGANIZED HOME CARE.

(2) Home Maker/Home Help Services

Home maker service, in the sense that an adult is sent to take charge of a family with children when parents are temporarily incapacitated, has been available recently in some centres of the Province. The needs of older people, where the requirement tends to be persisting, has been met on a much more restricted scale. The provision of home makers or home helps for the aged is a more limited undertaking than an organized Home Care Programme and involves supplying helpers who assist in cleaning, food preparation and personal services such as cutting of toenails (a most difficult task for some of our senior citizens). The skills needed are those possessed by most housewives, but the personality and attitudes of the people employed are of paramount importance. Those for whom the service is provided pay costs according to their ability.

IT IS RECOMMENDED THAT LOCAL COMMUNITIES AND ORGANIZATIONS UTILIZE THE FINANCIAL PROVISIONS OF THE PREVENTIVE SOCIAL SERVICES LEGISLATION TO

INITIATE OR EXTEND HOME MAKER/HOME HELP SERVICES FOR THE ELDERLY.

(3) Subsidized Housing

The phenomenal rise in rental costs in the Province of Alberta over the last few years has created a grave problem for many older citizens. Hardships resulting from living on a semi-fixed income during an era when inflation is accepted as the hallmark of a healthy economy are already considerable. Small increases in pensions which are intended to counteract changes in the value of money do not begin to cover the large increases in the cost of obtaining shelter. City renewal plans aggravate the problem, because rents in dilapidated and older houses near the centre of cities have tended to be cheap as compared to newer apartments in the suburbs.

IT IS RECOMMENDED THAT THE GOVERNMENT OF ALBERTA INSTITUTE A PLAN FOR SUBSIDIZED RENTS FOR SENIOR CITIZENS, AS WELL AS EXPAND THE EXISTING PROGRAMME FOR SINGLE UNIT ACCOMMODATION AND HOMES. THE AMOUNT OF THE PROPOSED SUBSIDY SHOULD BE BASED ON THE DIFFERENCE BETWEEN THE COST OF RENTING A MEDIUM PRICED ONE BEDROOM APARTMENT AND 25% OF PENSION.

(4) Information and Counselling Service

Many older citizens remain unaware of the services available to them. Others refuse to ask for necessary help because of their reluctance to accept aid from public funds. Some older people are understandably puzzled by the complicated forms they are required to complete before assistance can be granted. The management of finances, insurance claims, demands of landlords, etc., cause problems, especially to the newly widowed. There are numerous elderly people who rightly do not consider themselves in need of intensive therapy, but whose anxieties would be alleviated by the opportunity to talk over their problems with a sympathetic counsellor. The benefits to mental health through neighborhood centres offering easy access to this type of information and counselling are considerable.

IT IS RECOMMENDED THAT THE DEPARTMENT OF WELFARE ENCOURAGE LOCAL AGENCIES TO ESTABLISH INFORMATION AND COUNSELLING CENTRES FOR THE ELDERLY UNDER EXISTING FINANCIAL PROVISIONS OF PREVENTIVE SOCIAL SERVICES LEGISLATION. SUCH CENTRES SHOULD INCLUDE STAFF WITH EXPERIENCE IN LEGAL AND FINANCIAL MATTERS.

(B) MEETING NEEDS TO ENRICH LIVES

The Premier's White Paper on Human Resources Development laudably commits the Alberta Government to the provision of services which foster maximum development of each individual's potential. Potential development, it is worth emphasizing, does not cease in the later years of life, although the possibility of stagnation increases. There is considerable evidence that although a certain degree of withdrawal or disengagement from youthful activities is beneficial for the elderly, absence of occupation and a lack of activity has deleterious outcomes for mental and physical health. At present, the opportunities offered to older people to meet their needs for stimulation are meager. The following four recommendations are based on the idea of providing a variety of such opportunities. The aim is, to use the late President Kennedy's phraseology, not merely to add years to life, but to add life to years.

(1) Education

IT IS RECOMMENDED THAT ORGANIZATIONS RESPONSIBLE FOR ADULT EDUCATION PROVIDE DAYTIME CLASSES CATERING ESPECIALLY TO THE INTERESTS OF OLDER CITIZENS WITH APPROPRIATE TEACHING METHODS AT MINIMAL COSTS TO PARTICIPANTS, AND THAT ARRANGEMENTS BE MADE TO PROVIDE FOR TRANSPORTING STUDENTS WHERE NECESSARY.

(2) Employment

IT IS RECOMMENDED THAT THE DEPARTMENT OF LABOUR, AFTER CONSULTATION WITH INDUSTRY AND INTERESTED TRADE UNIONS, SUGGEST TO THE FEDERAL GOVERNMENT THAT SPECIAL SECTIONS OF CANADA MANPOWER CENTRES BE ESTABLISHED FOR REGISTERING THOSE RETIRED PEOPLE WHO WISH TO CONTINUE IN FULL OR PART-TIME EMPLOYMENT. The Canada Manpower Centres should embark on a programme of advertising, so that potential employers are made aware of this source of professional and skilled workers.

(3) Voluntary Work

IT IS RECOMMENDED THAT ALL VOLUNTARY SOCIETIES IN THE PROVINCE MAKE A SPECIAL AND CONTINUOUS EFFORT TO UTILIZE AND WELCOME THE SERVICES OF OLDER PEOPLE, thereby setting an example to the rest of the community that senior citizens, although often financially impoverished, have a wealth of experience and invaluable contributions to offer to society as a whole.

(4) Day-Care Centre

IT IS RECOMMENDED THAT THE DEPARTMENT OF WELFARE USING THE PROVISIONS OF EXISTING PREVENTIVE SOCIAL SERVICE LEGISLATION, UNDERWRITE 80% OF THE COST OF A PILOT PROJECT DAY-CARE CENTRE IN ONE OF THE MIDDLE-SIZED CITIES OF ALBERTA (E.G., RED DEER OR MEDICINE HAT), SUCH A CENTRE TO PROVIDE MANY OF THE FACILITIES SUGGESTED IN OTHER RECOMMENDATIONS, IN ADDITION TO A SHELTERED WORKSHOP. The centre should offer low cost nourishing meals, employ a full-time nurse for minor ailments, have counselling services, adult education classes and space for those who wish to participate in voluntary work. It would be essential to arrange for transportation, perhaps by school buses after school children have been taken to their classes in the morning and to their homes in the afternoon.

(C) PREPARATION FOR LATER YEARS OF LIFE

(1) Retirement Preparation Courses

In the United Kingdom and United States many commercial firms in conjunction with trade unions have instituted pre-retirement courses. Such courses have proved to be extremely valuable in reducing the inevitable stresses resulting from ending a lifetime of work occupation. The Alberta Council on Aging has formed a subcommittee to popularize schemes of this nature. This committee has gathered content material for a pilot project, which is likely to begin in one firm in the Province during the next few months.

IT IS RECOMMENDED THAT EMPLOYERS, TRADE UNIONS, AND EDUCATIONAL INSTITUTIONS SPONSOR RETIREMENT PREPARATION COURSES, THAT SUCH COURSES INCLUDE WIVES OF

EMPLOYEES AND UTILIZE THE SERVICES OF PRESENTLY RETIRED PEOPLE.

(2) Publicizing Information Concerning the Later Years

Special problems associated with aging processes cause less frustration when individuals enjoy good health. Furthermore, negative attitudes towards aging stem in large part from the equating of old age will illness. It is therefore of fundamental importance to publicize the well established hygienic rules for prevention of sickness (annual medical examinations, exercise and care of teeth are examples) and their paramount importance in the later years of life. Advice concerning such matters must come from the recognized professionals in the field and a special responsibility in this regard falls on teachers at all levels of education. They are influential not only in transmitting information, but also in the formation and changing of attitudes.

IT IS RECOMMENDED THAT SCHOOL, UNIVERSITY, AND ADULT EDUCATION COURSES IN MEDICINE, PHYSICAL EDUCATION, RECREATION, DENTISTRY, BIOLOGY, SOCIOLOGY AND PSYCHOLOGY PLACE FAR GREATER EMPHASIS THAN HERETOFORE ON MATERIAL CONCERNED WITH THE LATER YEARS OF LIFE.

(D) RESEARCH AND TRAINING

Many of the recommendations already made in this brief can be considered as examples of action oriented research projects. There is also a need for fundamental research into psychological, sociological, biological and economic aspects of gerontology. In addition, investigations which emphasize the translation of old and new findings in these areas from pure science into application deserve special support. Further, the dearth of relevant age-related statistics concerning poverty, housing, prevalence of mental ill-health, accidents and training the unemployed results in important gaps in the information available on the extent of problems of aging. The impetus for a greater research effort and the stimulation of students' interests in following careers in gerontology must come from faculties of universities. At the present time there is no institute or centre in the whole of Canada which specializes in the investigation of normal aging problems. One of the unfortunate results of this absence is that short courses for practitioners are rarely offered in Canada, and when available they must be staffed by recruiting trained personnel from the United States, which itself is experiencing a shortage of such people.

IT IS RECOMMENDED THAT THE ALBERTA HUMAN RESOURCES RESEARCH COUNCIL MAKE AN ANNUAL ALLOCATION OF $150,000 FOR RESEARCH INTO GERONTOLOGICAL PROBLEMS AND THAT IT DISCUSSES WITH AUTHORITIES OF THE UNIVERSITIES SITUATED IN ALBERTA MEANS BY WHICH AN INSTITUTE OF GERONTOLOGY CAN BE ESTABLISHED.

ACKNOWLEDGEMENT

The Alberta Council on Aging wishes to express its sincere appreciation to Professor A.E. David Schonfield for his efforts in the preparation of this brief.

SECTION 3 COMMENT FROM ALBERTA MENTAL HEALTH STUDY

The Director and members of the Study wish to commend Professor A.E.D. Schonfield and the Alberta Council on Aging for their fine submissions, which have been reprinted in their entirety at Sections 1 and 2 of this Chapter. Their case on behalf of the elderly of this Province has been well and truly documented. Their recommendations are supported without reservation.

WRNB

CHAPTER 16

NORTHERN MENTAL HEALTH PROBLEMS

Committee

Chairman:	Dr. D.K. Miyauchi	Department of Psychiatry Foothills Hospital Calgary
Members:	Dr. P.O. Davidson	Department of Psychology University of Calgary
	Dr. Charles Hellon	Department of Psychiatry University of Alberta
	Mr. A.G. Scott	Department of Educational Psychology University of Alberta

CHAPTER 16

NORTHERN MENTAL HEALTH PROBLEMS

INTRODUCTION

This committee was faced with a rather overwhelming task of assessing the mental health needs of the citizens of northern Alberta which represents over one-half of the land area of Alberta. Implementation of any kind of mental health service presents obvious problems. First, the area has a very low population density. Grande Prairie is the largest centre but it has less than 15,000 people. Second, there are great distances between major communities. For example, the distance between Grande Prairie and Edmonton is approximately 285 miles. Third, there are very few trained mental health personnel in the area. Fourth, there is no existing mental health facility in northern Alberta excluding the Guidance Clinic in Grande Prairie.

For the purpose of the study, it was decided to consider northern Alberta on a regional basis to try to overcome the problem imposed by its geography. Northern communities, which are within a 150 mile radius of Edmonton, were not considered because it was believed they could be best served by Alberta Hospital, Edmonton. When this segment of northern Alberta is set aside, most of the remaining population is found within a 150 mile radius of Grande Prairie. It is also apparent that the major communities of Fort St. John and Dawson Creek, in the British Columbia block of the Peace River country, could easily be considered in this region if interprovincial agreement were obtained. The only major-sized Alberta town outside the Edmonton and Grande Prairie regions is Fort McMurray. Other smaller communities, which are not included, are High Level, Fort Chippewa and Fort Vermilion. The smaller communities outside the regions under consideration, would require specially arranged mental health services.

Other factors which prompted the consideration of northern Alberta on a regional basis were:

1. The provision of service to the north from Edmonton poses a difficulty because of the distance.

2. The Peace River block requires diversity of methods and flexibility in meeting the local needs. At this stage of development, a comprehensive mental health program does not seem economically feasible for a population of roughly 85,000 people.

3. The mental health principle of continuity of care commands attention in the form of establishing community-based facilities, whenever possible.

4. The Public Health Unit and the Guidance Clinic are already dealing with the Peace River block as a region. The practice could well be extended to the development of other regional services, the establishment of community psychiatry, and the coordination of all mental health resources.

The committee concluded that this specific geographical area could support only one major psychiatric facility. For this reason, Grande Prairie, as the largest centre, was the only place visited by the committee.[1]

Grande Prairie is the logical centre for the establishment of a psychiatric unit for several reasons:

1. It is the major medical centre in the Peace River country.
2. It is the headquarters for the Peace River Health Region.
3. It is the centre for other regional headquarters of the government.
4. It is the largest centre in the Peace River country with the services of a city.
5. It has existing agencies in the community.

On the other hand, Grande Prairie, like other northern locations, is considered to be an isolated community by mental health personnel, both geographically and professionally. Special compensation probably would be required to attract the necessary personnel. In addition to higher salaries, more opportunities would have to be provided to attend conferences and seminars and to hold joint appointments or conduct private practice. It would also be desirable if Grande Prairie could be considered a practicum location by the University of Alberta Hospital for training in community psychiatry. Professional liaison of that kind with a major centre would lessen the degree of professional isolation which might otherwise be felt.

The inventory of existing mental health facilities and agencies reveals:

1. There are very limited psychiatric services in the Peace River country. The Guidance Clinic serves this area but a considerable part of their time is devoted to school problems. A visiting private psychiatrist provides his services four days per month. Most of the physicians are thus left to look after their psychiatric patients without the benefit of a consultative service.
2. There is no hospital unit for the treatment of the mentally ill.
3. There is no physical facility for the management of disturbed children and adolescents.
4. There is no formal arrangement with psychiatric units in Edmonton to receive psychiatric emergencies from the Peace River country.
5. There is no follow-up care program for the discharged patients from mental hospitals because of a lack of liaison between the mental hospital in Edmonton and physicians in the north.
6. There is a fragmentation of health resources and health services because of a lack of interdepartmental liaison (welfare, health units, guidance clinics).

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[1] A late brief was received from Peace River urging the establishment of a facility there. It is considered that their case, at present, is weak in comparison with the one for Grande Prairie. They will require a psychiatric unit in their local hospital, however, in the future. Their brief is at Appendix 1. WRNB.

7. The provisions for continuing education of professionals, who are directly or indirectly involved in the mental health field, are quite insufficient.

8. The following facilities are in existence in Grande Prairie:

   a. Peace School of Hope for Retarded Children
   b. Family Social Service
   c. Guidance Clinic
   d. Provincial Welfare Department
   e. Canadian Mental Health Association
   f. Victorian Order of Nurses
   g. Active Ministerial Association
   h. Auxiliary Hospital
   i. Nursing Home
   j. Public Health Unit

The committee considered that a psychiatric unit should be established in Grande Prairie because of the following factors:

1. Local administrative control is required to meet the diversity of problems in the area.

2. Continuity of care is best provided within a person's own community.

3. Coordination of all local health services can be achieved effectively, only by local arrangements.

4. The family physicians in Grande Prairie left no doubt that they are ready and willing to undertake the management of mental illness if proper facilities and psychiatric consultation are made available.

5. There is a need for a unit if the mentally ill of the region are to receive the same quality of care, and as readily, as persons with other illness. A unit, which makes use of psychiatrists as consultants, family physicians and other health personnel, strategically located, is clearly required.

Briefs

Four briefs from Grande Prairie are to be found with one from Peace River at Appendixes 2 to 5. Summaries of other briefs will be published in Vol. II.

Authors of the Grande Pairie briefs were virtually unanimous in favouring a separate mental hospital, instead of a psychiatric unit within the general hospital or an integral part of it. This point of view appears to be related to: a lack of sufficient knowledge regarding developments over the last decade in the management of mental illness; some concern about homicide and suicide rates, which are believed locally to be above the provincial and national averages; and apparent preoccupation with the most severely disturbed part of the population, which is a very small minority of those requiring attention.

Dissenting voices expressed a preference for a psychiatric unit or an annex or wing, adjacent to the general hospital, but essentially a part of it.

Estimates of requirements in terms of beds per 1000 of population were generally excessive. They could not have been based on a short-term active-treatment concept, which is essential. It is recognized, however, that all estimates (the highest was 250 beds) were based on the desire to keep all patients in their community, even those for whom permanent provision to the end of life must be made. The use of auxiliary hospitals and special nursing homes, in that context, did not receive sufficient consideration. Needs for long term care should be met outside the psychiatric unit but still within the community.

The Study Group can not support the bed capacity recommended in the briefs. The size, which is supported by all available evidence, should be adopted and given a thorough trial.

The briefs were completely unanimous in urging action to provide treatment facilities in northwest Alberta for the mentally ill, without any further delay. The committee supports that view. It was impressed by a clearly apparent need, which should require no more documentation. It shared the feeling of frustration of the community over lack of governmental action to provide adequate facilities in the community, despite repeated briefs and requests.

However, the Study Group rejects the idea of a separate mental hospital for the Grande Prairie region. Current evidence suggests they will probably be replaced gradually by other kinds of facilities. Meanwhile, Alberta has enough long term beds in long term mental hospitals to satisfy provincial needs for years. The major requirement now is for short term facilities to provide active treatment and these should be located in general hospitals or as an integral part of general hospitals.

RECOMMENDATIONS

1. A psychiatric unit should be located in Grande Prairie as an integral part of the existing general health facilities, not something separate organizationally or professionally. The unit should come under local administrative control, as a part of the Municipal Hospital. Its construction is a matter of high priority.

2. The psychiatric unit should have no more than 60 beds as a start, having regard for Yorkton's experience where approximately .7 beds per 1000 of population have proven sufficient to attend to all mentally ill persons in the region who are not chronic cases. A larger ratio may be required in the north if clinical judgement regarding incidence is supported by factual evidence.

3. Forensic problems and patients, who require long term or highly specialized care, should be referred to the Alberta Hospital, Edmonton.

4. A consulting psychiatrist should be made available. He should have a full-time geographical appointment with an adequate basic salary. In addition, he should have a consultative practice and, desirably, a sessional appointment with the Department of Psychiatry at the University of Alberta in the field of Community Psychiatry.

5. Higher salaries than those prevailing in urban areas should be paid to attract psychologists and social workers and they should have relatively more opportunities to attend seminars and conferences.

They should also be encouraged to accept joint appointments with the existing Junior College.

6. The possibility of developing, with British Columbia, a joint, comprehensive mental health program for the Peace River country should receive further study.

7. A close watching brief be maintained by local, regional and governmental authorities to ensure that the needs of the region are being met, having regard for possible variations in incidence and the relative isolation of communities such as Peace River.

PEACE RIVER MUNICIPAL HOSPITAL

"Enclosed please find a brief presented this morning to the "Mini" Cabinet of Mr. A.O. Alborg, Mr. E. Garhart, Mr. F. Colbourne, Mr. R. Clark, Mr. A.O. Fimrite. This brief was presented by me and I felt it was well received.

It was brought to our attention by Mr. Clark that we should have made representation to your Commission on Mental Health. I understand there will be a public seminar held in Calgary October 25th, 2 o'clock at the Jubilee Auditorium. It is my intention to be there accompanied by the Hospital Administration and a representative from the Chamber of Commerce to formally present our brief.

I wish to apologize for the delay in bringing this to your attention. I hope that our appearance on Friday the 25th will give you the opportunity to question our presentation.

I would like to point out the fact that we are a Regional Referral Hospital and have the Provincial Gaol ten miles outside the Town of Peace River. The Provincial Gaol has already made arrangements for Psychiatric facilities.

Yours very truly,

(signed) J.H. Schropp, M.D."

PEACE RIVER CHAMBER OF COMMERCE

In regards to the problem of mental health in the Peace River area, it is felt by the Peace River Chamber of Commerce that there is a real need for professional help in this field.

The following are some of the areas where a Psychiatric Service is needed:

1. At the Provincial Gaol here, three or four people per month are being sent out to Edmonton because proper diagnositic and treatment facilities are not available here. This number will increase as the number of inmates increases. This is a considerable cost in the transfer of these people to and from Edmonton.

2. At the Peace River Municipal Hospital in 1967 there were approximately 142 people admitted under mental, psychoneurotic and personality disorders. Of this number, 10 were sent to Edmonton for further treatment. These figures do not include those people who are referred by our local Doctors directly to Edmonton for diagnoses and treatment. There are also people who travel regularly to Edmonton for psychiatric treatment as out-patients.

   The Peace River Municipal Hospital with some additions to the building could be equipped with the necessary facilities.

3. In the field of Public Welfare the need for Psychiatric Services is greatly needed to assist in such things as dealing with children from broken homes and the parents themselves. Also it is suggested that in some cases parents who agree to take in foster children should be checked to be sure that they are the right type of people to be able to handle these children who in some cases can be mentally distrubed to some extent.

4. Members of the Peace River Ministerial Association agree that Psychiatric Services are badly needed. All too often they have to deal with people who have the serious type of problems that should be dealt with by a Psychiatrist. They say there are far too many suicides in this area for our population.

5. The Peace River Municipal Hospital Board would like to provide these services and have corresponded with the Department of Health on this question. The medical staff feel also there is a need for Psychiatric Services in this area.

6. The District Family Court Judge has children brought before him who suffer from brain damage due to environmental circumstances and at present there is no place to properly care for these children. He believes a Psychiatrist is urgently needed and also facilities made available not only for their care but also for the diagnoses and treatment of their parents. For the children's care he envisions a type of lodging in a small community, centrally located where these children could develop responsibilities toward people outside of their own families.

Therefore be it resolved that the Peace River Chamber of Commerce ask the Provincial Department of Health to give serious consideration to this problem and to provide facilities at the Peace River Municipal Hospital for this type of service.

GRANDE PRAIRIE MEDICAL STAFF

This brief is presented by the Medical Staff of the Grande Prairie Municipal Hospital for presentation to the Alberta Mental Health Study Committee on Northern Mental Health under the chairmanship of Dr. Miyauchi.

The intention of the brief is to state the need for physical facilities and the development of an integrated program for the prevention, diagnoses, treatment, and care and rehabilitation of the mentally ill in this area.

The area north of Edmonton comprises more than one-half the land area of Alberta and with the exception of a visiting psychiatrist and Guidance Clinic, it does not have any facilities in the mental health field. To visit patients at existing facilities at Edmonton, some people of our district, e.g. Fort Vermilion, must make a trip totalling 1400 miles.

The centre of population in Alberta is gradually shifting northward and in the past ten years has moved from a point north of Calgary to a point just south of Edmonton. Major developments such as tar sands, pulp mills, scrubbing plants, opening of 200,000 acres of agricultural land assures that this northward shift will continue.

The history of intense efforts to obtain mental health facilities for the north goes back some ten years and precedes efforts of such people as Karen Harding, David Barr and M.L.A. visits to Oliver which have lately drawn attention of the public to the field of mental health. In 1964, the north area was visited by Drs. Michie, Sprague, MacLean who were to study our mental health needs and report directly to the Minister of Health. No copy of their report has ever been obtained.

The population of northwestern Alberta known as the Peace River district has a population of 80,000 and using national averages of need, 3 bed/1000 should have as facilities of some 240 beds to serve our needs. Various proposals ranging from psychiatric unit to an active mental treatment centre on the hospital grounds have been put forward in the past with no results or commitments. The 240 bed facility is near the optimum figure suggested by the Royal Commission on Health Services.

There are two issues at stake in any discussion of our mental health needs in the north, our desperate need for facilities and the form they will take. In the past, our efforts have perhaps been distorted by various views as to what form the facilities should take until the total need was lost sight of.

It is not the intention of this brief to stress any form of facilities; this is best left to experts in the field and this study group.

There are many advantages to considering Grande Prairie as the site for a mental facility:

a. The largest population centre of the north.

b. Good road and air communication to Edmonton and rest of Peace River country for consultants, etc.

c. Presence of an accredited hospital and largest core of medical staff to provide other medical services for mentally ill.

d. Availability of serviced crown land.

e. A willing population that is not averse to the idea of a mental facility being in their midst.

f. Our experience in the past to obtain professional staff, e.g. Ph.D.'s in Agriculture for Beaverlodge and Junior College has been good and above expectations.

g. Good para medical services, dentists, radiologists and visiting pathologists are available in the area.

h. Good recreational department in city which could be involved in occupational work and recreational activities of the mentally ill to further their return to an active normal life.

In conclusion, in view of recent announcements as to the hope of donating 1% of our health budget in future to underdeveloped countries, the addition of another 300-odd beds at Oliver, the building of more, newer buildings at Ponoka, perhaps this commission could give a logical answer to the Albertans of the Peace River country why no facilities are being provided in our district.

GRANDE PRAIRIE MUNICIPAL HOSPITAL

This brief is submitted by me as a private practitioner in this city and not in my capacity as President of the Medical Staff of the Grande Prairie Municipal Hospital and is intended to reflect my own personal position on mental health needs and not necessarily to reflect the views of the Medical Staff as a whole though I trust it will complement the case set out by Dr. J.H. Storcer on behalf of the Medical Staff.

I envisage the area to be covered by a proposed new psychiatric unit to involve what is commonly referred to as the Alberta Block of the Peace River Country and which, in fact, corresponds to the proposed Peace Health Region as defined in Bill 87 presently before the Legislature. This area has a population which has been variously estimated at between 80,000 and 85,000 people. For reasons which will doubtless be set out by other briefs, this population can be expected to rise sharply within the next few years. For reasons which I propose to enlarge upon, it seems illogical that this population should continue to have its mental hospital needs served by a unit which is nearly 300 miles away from its largest population centre.

Certain positive and negative aspects of Grande Prairie's claim to an adequate psychiatric in-patient unit must now be enumerated. For whatever reasons and justifications there exists an almost total lack of liaison between the staff of the major mental hospital to which patients are referred from here and the referring physicians. Thus it has occurred on several occasions that patients are discharged to the community without the referring physician being aware that they have left hospital, what medications they are taking, or what precautions should be taken in their management and what follow-up might be required. On several occasions the first knowledge I have had that a patient has returned from Edmonton is that he has sought treatment from me in an exacerbation of his mental illness. In the three years that I have practiced in Grande Prairie, I have only on one occasion received a report of a patient's discharge from the Alberta Hospital in Edmonton.

The distance from Grande Prairie to Edmonton creates considerable difficulties for relatives who may wish to visit their kinfolk in hospital. Because of the distance involved there is a definite reluctance in my experience of patients to enter Mental Hospital in Edmonton as voluntary patients. I can cite several instances where I have felt that a patient would be eminently suitable for voluntary admission to a psychiatric unit in their own community but have required transfer to Edmonton against their will because our already over-crowded General Hospital lacked the facilities to manage these patients. They are therefore treated under less than ideal conditions, if for no other reason, than they are geographically widely separated from their environment and are initially hospitalized with an air of coercion.

In 1967, 229 patients with either a primary or secondary diagnosis of psychiatric illness used 2,103 days of hospital time here in a Unit which is not orientated to their special needs and which is already strained to accommodate the physically sick. Statistics, which will no doubt be produced elsewhere, appear to support the contention that the percentage of psychiatric admissions to Grande Prairie Hospital is continuing to rise each year.

On the more positive side, we in Grande Prairie have the only fully accredited hospital of any stature in northwestern Alberta and are designated as a referral centre for this area so that we are in a position to deal with physical illness as it arises in the mentally sick patients. We also have a medical staff which is active in its medical interests outside the usual run of the mill treatment of patients as evidenced by a sponsorship of frequent post-graduate studies and the number of members who attend seminars elsewhere each year.

Grande Prairie is not only the largest centre within the Alberta Block of the Peace River Country but has the best communications by air, road and rail with outside centres, so that should consultant advice be required for patients in a psychiatric unit it would be far simpler for physicians travelling here from, say, Edmonton to act in an advisory capacity rather than travel to other centres within northwestern Alberta. Apart from the medical facilities which Grande Prairie could offer, it would be in a much better position to provide the lay work force required to staff an adequately sized hospital and would also be able to provide the educational needs and commercial interest to attract the staff from outside.

We live in an area of Alberta which provides a not inconsiderable amount towards the provincial revenue and we feel that we have the right to facilities commensurate with our value to the Province. We are not satisfied with the mental health facilities at present available and we certainly do not consider that the proposed addition to beds to the Alberta Hospital in Edmonton will in any way improve the situation in our part of the Province. Here in Grande Prairie we can offer good facilities for a high grade psychiatric unit which will be of benefit to all people in northwestern Alberta and will lessen the strain on facilities within the rest of the Province.

Our area is growing and will continue to grow providing it is not stifled by a lack of encouragement and support from outside. We can no longer tolerate a situation where we play the role of Cinderella in a Province that is purported to be one of the most affluent in Canada.

Bruce Pitt-Payne MRCS (Eng.)
LRCP (Lond.)
President of the Medical Staff
Grande Prairie Municipal Hosp.

GRANDE PRAIRIE MUNICIPAL AND AUXILIARY HOSPITAL BOARDS

This brief has been prepared by the Boards of the Grande Prairie Municipal and Auxiliary Hospitals for presentation to the Alberta Mental Health Study, Committee on Northern Mental Health under the Chairmanship of Dr. D.K. Miyauchi.

The intention of the brief is to state the need for the physical facilities and the development of an integrated program for the prevention, diagnosis, treatment, care and rehabilitation of the mentally ill in this area.

Area

The area referred to is considered to be co-terminous with proposed Peace Health Region as defined in Bill 87, presently before the legislature. This area had a population of 77,000 in 1965 and is now estimated at 85,000. Completion of A.R.R. will probably result in a substantial increase in this population figure within the next five years. Grande Prairie, the centre of greatest population is 300 miles from closest mental care institute.

Present Health Facilities

The 85,000 residents of this area are presently serviced by 597 active treatment beds, 135 auxiliary (chronic and convalescent) beds and 190 nursing home beds. These medical treatment and medico-custodial care beds are serviced by 48 active medical practitioners. Area is presently serviced by two Medical Health Officers, one and one part-time Dental Officers and twenty-six Public Health Nurses. Permanent Guidance Clinics and visiting Cancer and T.B. clinics have been established. Of noticeable concern - no mental health facilities.

Utilization of Health Facilities

Statistics available to our boards indicate the following:

Yearly admissions--

Active treatment hospitals	22,000
Auxiliary hospitals	200
Nursing homes	100
Total Admissions	22,300

In 1967 the number of patients admitted to Grande Prairie Municipal Hospital with primary or secondary diagnosis of mental disorders was 5% of the total admissions. On this basis the number of patients with a diagnosis of mental disorders admitted to all area hospitals would be 1115.

Need for Mental Health Facilities and Care

The foregoing indicates medical facilities and care have been established for those requiring physical aid and care but facilities for mental treatment and care have been neglected. In view of the fact that your committee has available exact statistics and information in regard to the number of patients presently being cared for in institutions outside this area and the annual demand for this type of care it would appear redundant to state those figures derived from our limited statistical information. However our figures do indicate this area has approximately 1000 persons per year requiring treatment and care for mental disorders of varying degree. This figure can only be revised upwards and does not include the approximately 170 patients presently being cared for in institutions in Edmonton and other southern Alberta centers.

Requirements

If the most beneficial and permanent results are to be achieved it is our opinion mental patients should be treated and cared for as close to their normal home environment as possible. We consider that for the good of the patient and their families those patients presently in institutions some three hundred miles more or less distant, should be repatriated. We acknowledge that there are and will be specific special cases that it will not be reasonable or practical to treat and care for without the help of specialists and special facilities. Notwithstanding we consider a minimum of 80 to 100 beds are required to accommodate primary and/or repeat cases and 150 beds for long term and unrehabilitable cases, or a total of 250 beds. This would not release the active treatment hospitals from admitting this type of patient for observation and/or temporarily pending transfer. We consider it to be imperative that adequate and qualified staff at all levels be available as well as requisite special services. It is also considered of paramount importance to have an adequate out-patient service available on a 24 hour a day basis. As hospital boards we understand that basic standards for the above are agreed to by all those concerned with mental health and we do not consider ourselves qualified to set forth arguments on the specifics involved.

Location

It is our considered opinion that any mental health facilities should be established in the center of greatest population and existing health facilities. From the point of view of economics and also to avoid as far as possible, segregation of mental patients, it would be advisable to consider establishment of the facility as a part of an integrated hospital complex or at least close enough to an active treatment hospital that there could be a sharing of services and special services.

General Comments

The Boards of the Grande Prairie Hospitals have, over the past several years, presented many briefs and requests for mental health facilities for this area. It is almost inconceivable that in a province as affluent and modern as Alberta, that authorities have not considered the citizens of this area entitled to the same consideration in the care of mentally ill as are the citizens in the southern half of the Province. We would doubt that even in some of the more backward countries of the world that mentally ill are required to travel up to five hundred miles for treatment. We have not indulged in any detail in regard to specifics such as the attempt to treat mental patients in active hospitals without adequate staff or facilities and the resulting effect on overall patient care, or the type of facility and staff as might be required for proper care of mental disorders, as we consider members of the medical profession and other professional and technical groups are far better qualified to deal with these areas.

Grande Prairie Auxiliary Hospital Board.
Grande Prairie Municipal Hospital Board.

THE NURSING STAFF OF THE GRANDE PRAIRIE HEALTH UNIT[1]

Introduction

Health Units have been in existence in Alberta since the 1930's and at the present time 95% of the population of Alberta is covered by Health Units or Municipal Nursing Services. Public Health Nursing is professional nursing that, through organized community effort, serves people in their usual environment of home, school, and work. The objectives of Public Health Nursing are:

1. To prevent disease and defect.
2. To prolong life.
3. To promote general health and well-being, including physical, mental emotional, social and spiritual health.
4. To effect continuity of care.

Why Our Concern

All of our objectives are applicable to the Mental Health Field.

1. To Prevent Disease and Defect

Our nurses carry on a regular home visiting program in many areas.-- New babies, rheumatic fever, tuberculosis, school follow-up, and many more that give us an easy access to the home. Public Health Nurses are usually welcome visitors and people use them as a sounding board for their problems. As the nurse goes into the home and school freely, she is often told of problems or changes in family relationships before any other person is consulted. Referrals to family doctors or encouragement to see a doctor is a part of our routine. We also encourage a wider and broader use of the Guidance Clinic than just referral of schildren with school and emotional problems. Marital problems and family counselling are also suggested as part of our program. As we have only two psychologists and one social worker covering an area of about 40,000 square miles, you can judge that the work load is great and travelling time is extensive. Psychiatric facilities with a well developed out-patient and prevention program would be a great asset for these members of our society and would relieve the already over-burdened family doctors. Nurses could also develop a workable referral program with a psychiatric hospital out-patient department.

Further to the prevention of more mental health problems, we have to consider the manner of referrals to the Eugenics Board. Now patients must go out to Edmonton for assessment and surgery. As a result of this costly procedure in time, travel and accommodation, many young adults are not being referred. Many parents do not understand the procedures and hesitate or refuse to have their children sterilized. As a result, future generations of mentally defective children and mental health problems can be anticipated.

2. To Prolong Life

In 1966, our Health Unit's annual statistics show that the suicide rate for our area was more than twice the Provincial rate and almost three times the

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[1] A shortened version of the original. WRNB

Canadian rate. Similar rates were also noted for 1964 and 1965. In 1967, our suicide rate dropped but still is higher than the Alberta and Canadian rates. Our homicide rate has increased sharply. Our Health Unit covers 18,000 square miles and has a population of 36,317 people (1.9 persons per square mile).

3. To Promote General Health and Well-Being

Physical, mental, social, emotional and spiritual health

Today nurses are concerned with total patient care and each of us tries to deal with their patients in such a manner. To provide pre-natal care, excellent maternity and nursery services, and then not able to deal with a post-partum psychosis, is most disheartening and frustrating for a nurse.

Let us deal with each aspect of health separately:

Physical

In the South Peace River area, we have a total of one health unit, three municipal nursing services and five hospitals. Intensive care units, cardiac units, emergency departments, plus the general services of any hospital are well developed or being developed. Seminars, workshops and continuing education programs are in effect for doctors and nurses. The Cancer Clinic visits Grande Prairie every two months. A Tuberculosis Clinic is held here twice a year. Until two years ago, a Travelling Diagnostic Clinic visited regularly in the area. Patients referred out to Edmonton for medical or surgical treatment are usually only gone for two or three weeks and can return to their community hospital or homes for continuing serviellance. Specialists in Edmonton, on returning the patient to their home area, send complete reports to the family doctor so that follow-up is integrated with treatment. When the patient goes home, we have a Victorian Order of Nurses Branch who can do follow-up home visits for dressings, injections and general nursing care. She provides this service under the direction of the family doctor.

Mental

We do not have any mental health facilities north of Edmonton. Our general hospitals, which do not have the physical plants to deal with the mentally ill, are our only means of treatment for these people. Nursing staffs, who should have time to spend with the mental patient to try to discover their problems and assist with prevention and cure, are busy caring for the physically ill. Consequently, the mentally ill suffer. If we were to consider the area covered by Grande Prairie, Peace River, and High Prairie, we would have an area of 40,000 square miles. Our population would be about 90,000. In 1967, the population of Alberta was one and a half million people. Using the 1966 figures of admissions to Alberta hospitals, which were 3,472 people, we could expect about 200 people from the Peace River block to be admitted to mental hospitals each year.

At the present time, we have a branch of the Alberta Guidance Clinic with head offices in Grande Prairie covering the above mentioned area. It is staffed by two resident psychologists, one social worker and a clerical staff. A great many of their referrals are school orientated and assessments for school placement. They are trying to encourage adults with marital, family, social problems and alcoholism to use their services and this is a developing program.

Since last fall we have had a psychiatrist visit Grande Prairie every two weeks for two days or a total of four days a month. His services are so much in demand that he is booked up a month or more in advance. He works on the average of twelve to fourteen hours a day to cope with his patient case load.

Social - Emotional - Spiritual

A branch of the Preventive Social Services is organized in the city and county of Grande Prairie. We are attempting to set up a Family Service and Homemaker's Department. We are investigating the possibilities of a Big Brother - Big Sister program in Grande Prairie and a Head Start program in one area of the County. We have a well developed Ministerial Association whose members are called upon for counselling, as well as Welfare, Guidance Clinic, family doctors and health unit. As a result of lack of direction, often many agencies are involved with different problems in the same family. Guidance counsellors are also located in the Grande Prairie schools and one in the County school. Their work load is such that they often cannot devote the necessary time to children in schools with problems as they are presented.

4. To Effect Continuity of Care

The problem of transporting mentally ill patients to Edmonton is appalling. Each patient referred out for treatment must make a three hundred mile trip by plane, car or ambulance from Grande Prairie. An escort consisting of the police, a nurse or attendant is required. These patients must be heavily sedated for transfer. The embarrassment to the patient of being hauled off by the police should be avoided if possible.

Again, this is a costly procedure for the patient and government as these attendants must be paid. Sending our citizens to Edmonton poses still another problem; visiting. We are not a wealthy area of the Province with an average income of less than $5000 a year. A trip to Edmonton to visit a relative requires three days and two nights stay or two nights on the bus with a day to visit. Visiting hours at the Provincial hospitals are limited. Not everyone has relatives in the City with whom to stay. Often patients going to Edmonton are not seen by their relatives or friends during their whole stay. When observing average incomes, the length of stay required to visit is a very costly factor and an apparent deterrent to the maintenance of family relationships.

What a Hospital Could Do in the Peace River Area

We sincerely feel that an active treatment hospital of at least one hundred beds, with out-patient and preventative facilities is required in our area. The Grande Prairie Hospital which has one hundred thirty beds, admitted one hundred twenty-six mentally ill patients for a total of nine hundred seventy-nine patient days during 1967. We are a young population with our population divided into one-third pre-schoolers, one-third in school and one-third adults. We realize that we represent only about six per cent of the population of Alberta, but this is a growing, expanding area, accompanied by many stresses and strains not associated with well developed cities. We are told that family counselling and therapy are often needed for the complete recovery of the mentally ill. This phase of mental health is often non-existent with our present lack of preventive services and no full-time psychiatrist in the area. The establishment of a hospital and the development of a program for the mentally ill and their families may encourage specialists in this field to establish themselves here. Fears of a mental hospital amongst the general populace would lessen if they learned how a mental hospital operates. People would soon learn to accept the facilities available to them and use them readily. We would hope with this acceptance and an educational program that our readmissions to hospitals would lessen; people would accept treatment earlier and our suicide and homicide rates would drop accordingly.

What the Health Unit Could Do if a Mental Hospital Was Established in the Area

For many years Public Health Nurses have been concerned with the mental health problems they encounter in their routine home visits. Because we have easy access to homes, once people know us, they very often approach us with their emotional, mental and social problems. When a nurse discovers a patient returned home with a three month supply of pills, no referral to the family doctor or other agency, frustration with present procedures becomes evident. At the present time there is no referral program, as such, to any local agency. Follow-up of the patient, their medication, their return to the community is accomplished only if the citizens are accidentally discovered.

The Health Unit has a well-developed liaison and a home visiting program could be developed with a local mental hospital. At the present time, we do home-condition reports for referral to the Guidance Clinic and some supporting home-visiting. Welfare refers people to us when they suspect a mental health problem is involved, as do the schools and other local agencies. We visit these people and refer them to an agency that can best help them, very often their family doctor.

Our visiting psychiatrist who comes to Grande Prairie four days a month, has developed a referral program with us that appears to work effectively. Usually when a mental health problem becomes apparent in a family, it is found that all members require counselling or supportive help. This is an area where Public Health Nurses could assist greatly but we are also aware that we require guidance and further education along psychiatric lines. The referral program we have worked out with our local visiting psychiatrist includes home visiting on a regular basis, surveillance of medication, counselling, reporting changes in the mental condition to the psychiatrist and making appointments for further treatment and consultation.

At present, a liaison program such as this does not exist between the Alberta Provincial hospitals and any agency in our community or the family doctors in many cases. Supportive care to patients returning to the community is non-existent unless they are found accidentally. There are no half-way houses or out-patient services available to the patients as they learn to re-adjust to their families, communities and jobs.

Alcoholism

Another area of great concern for our nursing staff is the problem of alcoholism. The actual number of alcoholics in the area is not known but a rough estimate would be well over one hundred. The Grande Prairie Hospital admission figures for 1967, show twenty-nine alcoholics admitted for a total of one hundred seventy-two patient days. In a one hundred thirty bed active treatment hospital, this accounts for a great deal of bed space and nursing time. The disruption these people cause to medically ill patients when placed in large wards can be easily imagined. We do have an active Alcoholics Anonymous group in Grande Prairie but this only helps those people who realize that they have a problem and are seeking assistance. We have a developing program with the Division of Alcoholism, who are using the resources of the Health Unit and wish to expand and develop this program further. As many alcoholics and their families also require psychiatric help to prevent a recurrence, and to develop an understanding of their mutual problems, mental health facilities in this area would also accommodate this group of people. Again, the physical layout of our hospitals is not such as to accommodate and nurse these patients with ease or develop an educational program for them. As soon as they are dried-out, they are discharged and soon return to their old habits.

School for Retarded Children

In the City of Grande Prairie we have a School for Retarded Children. At present, there are forty students attending the school and about twenty-five of these children live in an attached dormitory. We have a waiting list of approximately eleven children for this school now with no future hope of expansion. Peace River hopes to develop a similar school but it won't be open before 1970. Older children are being kept at the school because entrance to Deerholme and the Red Deer Training School requires a long waiting period, often several years. Parents who cannot get their retarded children and adults admitted to any of these institutions face years of confinement and frustration in waiting for help with their offspring.

Sheltered workshops have not been developed in this area so that children who are fortunate enough to get into the school here must leave the area for further institutionalization or lead a life offering few rewards. When these children or young adults require hospitalization, they also need extra supervision or surveillance by the nursing staff, as special physical hospital set-up and special equipment for their protection and recovery from medical and surgical problems.

Liaison

I have mentioned the liaison we have with other agencies in Grande Prairie--hospitals, family doctors, visiting psychiatrist, welfare, School for Retarded Children, schools, guidance clinic, to name a few. We have developed liaison and referral programs with agencies in Edmonton such as Division of Alcoholism, Glenrose Hospital, Canadian National Institute for the Blind, School for the Deaf, specialists in medical fields and many others. Why such liaison cannot be established in the mental health field, until such time as we have our own facilities for prevention and treatment, is an inexplicable question.

Previous Requests

In August of 1965, the following submission was made to the ad hoc committee on the Special Legislative and Lay Committee inquiring into Preventive Health Services in the Province of Alberta.

"There is no release of information from Mental Hospitals to Health Units regarding patients admitted or discharged from hospital. If such information were available and if in-service training were provided to nurses by, say visiting psychiatrists, it is possible that a useful service in this field could be developed. For example, nurses could visit discharged patients and give advice on family problems and assess the patients' conditions with specific regard to spotting an impending recurrence of their condition. If such seemed imminent, a visit to the family doctor or visiting psychiatrist could be encouraged. Also, a check could be made on whether patients were taking their medication if this had been prescribed."

October, 1965: Nursing Brief to Special Legislative and Lay Committee.

"At present, health units are not notified of patients leaving the Alberta Hospitals and returning to their home. Many times there are situations in a community or home that the Hospital is not aware of, that may lead to another breakdown of the patient. Better education of the nurse in being able to recognize problems that would effect a mentally ill patient is needed. Also a mental hospital in the north would be an asset so that the patient can continue to know his family, friends and community."

Further reference can be made to the Report of the Special Legislative and Lay Committee Inquiring into Preventive Health Services in the Province of Alberta, pages 79 to 85 and recommendations, pages 188 to 210.

Conclusion

We feel a responsibility for the people of northern Alberta. They deserve services similar to the more populated and wealthy areas of our province. We are a young area, and our history is still being written. Let us try to follow the adage of "Helping others to help themselves" and grow into a strong, dependable area of the province, whose mental health and growth will match the will of the people who have pioneered and developed this area.

NURSING STAFF, GRANDE PRAIRIE HEALTH UNIT

CHAPTER 17

THE EUGENICS BOARD

The Eugenics Board of Alberta meets on an average of five times a year at various provincial psychiatric installations and mental deficiencies hospitals in the Province of Alberta in order to evaluate cases presented by superintendents for the consideration of sterilization under the terms of the Act. Sterilization is recommended by unanimous conclusion of the four-member Board and under the terms of the Act respecting patient and/or parent etc. permission for sterilization. The Board comprises two medical and two "lay" members. Approximately 25 cases might be evaluated in a two-day session of the Board.

The practice of sterilization is both sufficiently unusual in Canada and unique as a part of mental health practice to invite general comment in the areas of justification and effectiveness. Legislation regarding sterilization is also rather sensitive within the social and political framework of our society. This Chapter is a report on the operation of the Eugenics Board of Alberta and relates to Chapter 311 of the Sexual Sterilization Act of Alberta (1942). The subject was raised critically by one speaker at a public hearing and there was one vague reference to it in a brief. The Study provided an opportunity for examination of the subject and this comment.

JUSTIFICATION

Justification under the sterilization act is based on genetic-medical and social-psychiatric grounds. While sterilization of mentally retarded and mentally ill individuals is viewed by many as questionable, there is strong and accumulating scientific grounds in support of the practice; providing of course that board practices are based on stable biological and behavioral science's evidence. There is also growing opinion that society is approaching a period of serious concern for the erection of socially approved and morally defensible procedures for biological guidance of human populations. Such eugenics boards as do exist are an historically important precursor to future understanding of this problem, irrespective of present justification levels in science or of effectiveness in outcome. Constitutional and genetic bases for sterilization are reasonably well-rooted in genetic research related to the schizophrenias and to some of the affective disorders, but not with respect to psychoneuroses and certain other of the affective disorders. In the field of mental retardation simple Mendelian type conditions, sex-linked disorder and certain of the cytological disorders are clearly related to the production of defective progeny. In these cases sterilization is often justified on biological grounds, but not always (e.g. P.K.U.)

Social justification for sterilization is more equivocal than biological evidence but equally cogent. A number of exogenous mental retardation conditions and neuropathological mental illnesses lead to severe and chronic handicap. The likelihood in these instances is that progeny, while perhaps genetically normal, would have virtually no opportunity for viable nurture within the context of the biological family; or that the biological parent would be unable to control (within broad limits) the reproductive drives and thereby invite serious injury to self and others. There is little doubt, therefore, that eugenics programs are supportable in terms of biological and social sciences.

EVALUATION

Notwithstanding the foregoing comment the test of the place of eugenics programs in mental health services depends on the manner of operation.

1. Where genetic justification is employed for sterilization, board members try to be aware of those conditions which are established as dominant in transmission or recessive or polygenic or sex-linked and which cytological or chromosomal disorders are hereditable. Research evidence permits some differentiation of these categories and relevant identification laboratory procedures, are increasingly available. Down's syndrome provides an example. Other quite severe genetic conditions of mental arrest (P.K.U.) are now treatable on chemical and dietary bases and can no longer be as clearly supported for sterilization on either genetic or social grounds. Evidence of a genetic sort presented to the Board by the requesting institution is not always adequate in this respect. Requests for sterilization in Down's syndrome, for instance, are not accompanied by laboratory evidence in support of a diagnosis for trisomy-21, translocation or mosaic sub-types, the majority trisomy-21 not being of the transmittable variety and the mosaic sub-type often being less severe than other types of the syndrome. In the case of Mongolism however the distinction is often academic.

2. Sterilization requests based on sociological-psychiatric grounds should be accompanied by full case history, psychometric, and psychiatric reports. This is not always the case. There are instances of borderline candidates where genetic evidence is absent, and sociological factors are, if present, not necessarily irreversible. Sterilization of a borderline or dull normal retarded youth, based in part on cursory psychological data provided by unregistered psychological staff, is questionable. Neurological and laboratory evidence is often incomplete. Justification in such cases has been offered in terms of permitting a treatable patient relatively unsupervised "grounds" privileges. Further, the sterilization of individuals with depressed I.Q. ratings attributable to emotional or delinquency or sub-cultural (e.g., Metis) factors, which are capable of some degree of amelioration, is open to debate.

3. Causal evidence available to the Board is limited. Comprehensive etiological status studies based on pediatric, neurological, and bio-chemical examination are seldom available. The Board has difficulty in deciding in some cases between genetic and non-genetic causes and between conditions unlikely to remit and those which are capable of developmental compensation or change as a function of treatment or training.

RECOMMENDATIONS

1. That the Act be revised to specify appointment qualifications suited to the task of evaluating biological and social criteria as a basis for sterilization. That future members might be drawn from the medical subgroups of psychiatry, neurology and pediatrics, where possible. That a third position be designated for a human geneticist. That a fourth position be designated as a "citizen" position. That a fifth position be created for a qualified social worker or psychologist. That consideration be given to increasing the number of serving Board members to five, as above.

2. That candidates for review by the Board be presented in more than summary fashion and that presentations include qualified professional and technical reports appended to formal offerings. That supporting evidence for sterilization not be presented to the Board based on the findings of individuals who do not meet the minimum requirements of their own professional groups.

3. That complete documentation on candidates be presented to Board members some reasonable time before a convening of the Board.

4. That an appointment of an executive secretary to the Board be made (part time) to coordinate case history information and make these reports available prior to meetings, and to survey recent and relevant scientific findings for benefit of Board members (e.g. reprints).

In summary, the legislation is considered generally adequate and justly implemented by the Chairman and other members of the Board. The members exercise mature caution in doubtful cases and exert no pressure in cases where patient consent is required. One problem, however, relates to the dearth of broadly-based and specialized diagnostic services in support of efficient deliberation by the Board, especially with respect to borderline cases.

CHAPTER 18

ADDICTION

A Study Group on Addiction examined and reported on this topic during the course of the Alberta Mental Health Study. The composition of the Group was as follows:

Chairman:	Dr. Henry M. Wojcicki	Edmonton
Members:	Mr. Walter Boddy	Pharmaceutical Association Edmonton
	Rev. Hart Cantelon	Central United Church Edmonton
	Mr. Fil Frazer	Division of Alcoholism Edmonton
	Mrs. Joyce E. Irvine	Red Deer Family Service
	Inspector Marvin Marcus	R.C.M.P. Narcotics Division Edmonton

In addition, Dr. J. Edwin Boyd of the Department of Psychology, University of Calgary prepared a report on alcoholism. The final product, however, is an independent position, based only in part on their findings.

The terms "drug abuse" and "alcohol abuse" would have been better choices than addiction to describe the subject matter of this report. "Addiction", as generally used has a particular, narrower meaning. It implies: chronic intoxication, tolerance, psychological dependence, usually physical dependence, an overwhelming compulsion to continue using the addictive substance and detrimental effects on the individual and society. (Smith, Kline and French, 1967 : 29). The broader terms will be found in the report and, when addiction or "addictive" are used, they will have the above meaning.

The similarity between drug abuse and alcohol abuse is striking. The World Health Organization (1967) has suggested that they be regarded a single problem. It is apparent that both are forms of maladaptive behavior which, in the case of addictive drugs at least and alcohol, can lead to serious illness. Both present similar problems in treatment, prevention and control. In the context of this report, they are antithetic to good mental health, in that they impede the attainment of personal and social well-being. Both are also serious social problems, which have frustrated researchers, practitioners, teachers, law-makers and law enforcement agencies.

There are differences, however, which have important implications for the prevention of abuse. The use of addictive drugs is generally considered socially unacceptable, even immoral, in our culture. Severe penalties are associated with use, possession and sale. On the other hand, there are what could be termed "permissible" levels of drinking. Economic waste through excessive drinking, and the loss of life and property at the hands of drinking drivers, provoke verbal condemnation and severe regulations. However, attitudes toward drinking, generally, appear to remain unaffected. This ambivalence about drinking is in sharp contrast with the disapproval of use of addictive drugs.

It has been stated frequently that addicts and alcoholics are simply inadequate personalities. That may be so but acceptance of the notion does not assist with prevention and control. It is undoubtedly a major error to believe that a homogeneous kind of personality exists in either case. (Partington and Johnson, 1968 : 12). As with any other aspect of human behavior, single cause theories eventually have to be put aside. The more productive approaches always recognize the multiplicity of influences and causes and human variability. In other words, it can be expected that there will be many differences among people, who are alcoholics or drug addicts. It follows that no single method of treatment or prevention will be effective with every problem case. Just as there are different kinds of drug dependence, and variations within drug-dependent groups, the methods of treatment, control and prevention should not be expected to fall into a simple mold.

Incidence

Many guesses are available regarding the incidence of alcoholism in Alberta but there are no reliable data. The information, which is available, relates to admissions to mental hospitals (355 in 1966; 250% more than 1961) and the number of new cases appearing at alcoholism clinics each year (about 1000-1500 in recent years). However, it is probable that many cases of alcoholism are hidden in one way or another, sometimes under different labels at home, at work or in hospital, and always depending on the definition of "alcoholism" one chooses to apply. This kind of discussion is clearly not profitable. The extent and nature of the problem are simply undefined.

The Study also could not locate dependable information about the use of addictive drugs or the current "fads", marijuana and amphetamine, in Alberta. It has been estimated elsewhere in Canada that 7-13% of high school students in large cities have tried marijuana at least once. The figures for university students are variously estimated at 20-65% with about one-quarter "progressing" to L.S.D. It has also been asserted that amphetamines are being produced in "basement labs" in another province. Young people are said to be experimenting with more drugs and are using them in combination to an increasing extent. Some authorities consider the abuse of amphetamines has reached epidemic proportions. (Unwin, 1968 : 1). Regrettably, however, the Study has no reliable information to report on incidence or seriousness of drug dependence of any kind in Alberta. A special governmental committee has been investigating the problem under the Human Resources Authority. The Committee should continue its important work but, if they have not already decided to do so, they should launch some thorough-going, large-scale research to obtain data, which would aid in planning prevention and control. Two interns at the Foothills Hospital in Calgary are gathering information locally about drug usage in high schools but a much broader attack is required.

Treatment

Notwithstanding the lack of information, it is apparent that the current delivery system for the treatment and rehabilitation of persons addicted to alcohol is inadequate. Detoxification should be readily available but, at present, no agency or institution wants to be responsible; and, in fairness, it must be admitted that the "drunk" is an incredible nuisance. Frequently he ends up in jail or is transported to Ponoka or Oliver, adding unduly to the work loads of those institutions and interfering with their programs.

The acute alcoholic should be treated initially within his own community, or close to it, in the psychiatric unit of an active treatment general hospital. He is a nasty problem but he is out of place in a mental hospital, at least at that stage of his drinking "career." No acute alcoholic should be admitted to a regional mental hospital unless he is a very special case, who can not proceed through detoxification at a general hospital.

If a person becomes addicted to alcohol, a special ward of a regional mental hospital is one of the right places for him, because he is then mentally ill, beyond question. Longer term treatment involving milieu, behavior and drug therapy currently would represent the best hope for recovery in that setting. If he is willing to accept the reality of his situation and work toward his recovery, membership in the A.A. organization offers a promising chance to return to productive living.

After detoxification of the acute case, or detoxification and treatment in the dependent case, rehabilitation must follow. The alcoholic could be referred to the local "health and welfare unit" (a combination of health unit,[1] guidance clinic, alcoholism clinic and welfare unit), if he were judged capable of recovery from an out-patient facility. Alternatively, if he needed more support, another type of facility should be available. Some possibilities in that regard are half-way houses, boarding homes or even a kind of rehabilitation camp, but in each case the program should demand a responsible, self-supporting effort to regain confidence, personal effectiveness and dignity. In each case, also, some supportive counsel should be available. (This term has been used to distinguish a modest amount of guidance and an opportunity to talk about progress and problems from the usual depth interviews, "insight" therapy or "group" therapy, which have an unimpressive record with alcoholics.)

The following table offers one limited comparison of various kinds of therapy. Although there is much variation, behavior therapy shows the greater promise. It merits more critical study and experimental use in Alberta. Of course, other treatment approaches also should be explored and evaluated because behavior therapy can not be the only answer to mental illness.

TABLE 1

RESULTS OF VARIOUS STUDIES REPORTING FOLLOW-UP DATA ON TREATED ALCOHOLICS[2]

Study	Treatment	N	Follow-up	% Abstinent
Valance (1965)	Conventional treatment	68	6 months	20
		68	12 months	10
Blake (1967)	Electrical aversion	25	6 months	48
		22	12 months	23
Evans (1967)	White noise aversion	6	6 months	50
		6	12 months	33
Anant (1967)	Verbal aversion	25	8-15 months	100
MacCulloch *et al.* (1966)	Anticipatory avoidance	4	--	0

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[1] The "Ball Commission" also recommended involvement of health units in its report to the Government in 1966. (p. 84-85).

[2] Adopted from Evans (1968).

McGrath (1968) has recommended that legislation be enacted to provide for absolute and conditional discharge in relation to drunkenness. He points out the need for procedures which would permit: arrest when warranted; disposal by the courts without registration of a conviction (absolute discharge); differential treatment of occasional and habitual drinkers; and control over the offender while undergoing treatment (conditional discharge). In the last mentioned case, release to compulsory treatment would involve no registration of the offence if the conditions were met; otherwise, a sentence could result. (p. 80-83).

The reasoning and recommendations of the McGrath report in this context are supported fully by the Alberta Mental Health Study.

The same observations and conclusions regarding delivery of care and control should apply in the case of drug abuse and drug addiction.

The problem of marijuana and other "botanicals" is not so easily treated. According to Drug Abuse: Escape to Nowhere (1967) "Marijuana does not produce physical dependence or an abstinence syndrome"; "tolerance doesn't develop"; and "available information indicates that marijuana has few detrimental effects on an individual's physical health". The report goes on to say "Psychic dependence and the drug's effects, however, may lead to extreme lethargy, self-neglect and preoccupation with the use of marihuana to a degree that precludes constructive activity". The report also quotes a 1965 Bulletin of the World Health Organization: "Abuse of cannabis (marihuana) facilitates the association with social groups and subcultures involved with more dangerous drugs, such as opiates or barbituates." Here again, however, there would appear to be a need to separate evidence from pronouncements. It is clear that there is a good reason for concern. There is no justification, however, for panic, or extravagant statements about incidence, health hazards or morality.

Legitimate concern about marijuana should prompt strong efforts to disseminate widely any reliable findings about adverse effects and probable effects and, in addition, to do some systematic work locally to obtain more evidence. It would appear that the reported decline in popularity of L.S.D. is related to the spread of information about its harmful effects.

Dr. J.R. Unwin, Director of Adolescent Service, Allan Memorial Institute, Montreal, discussed the current dilemma regarding marijuana and the law in these terms (1968):

1. It comes under the Narcotics Control Act and carries the same penalties as narcotics like heroin.

2. Possession could cost a person seven years; trafficking, life imprisonment.

3. There is no provision for penalties for possession of L.S.D. under the Narcotics or Food and Drugs Act, but the implication that L.S.D. is less dangerous is not supported by medical evidence.

4. Notwithstanding the negative attitude of the World Health Organization toward relaxation of current national and international restrictions, "there patently are inconsistencies within the present laws related to L.S.D., marijuana, narcotics and alcohol." (p.11).

Although it might be argued that another intoxicant is not a major need of mankind, it is agreed that the current approach to marijuana is illogical and unscientific. The law in this case would appear to be not enforceable. Attempted enforcement seems to serve only to engender alienation and disrespect, which are not conducive in themselves to good mental health. In addition, the medical evidence indicates that the drug is not addictive and not a serious hazard in physical health, although excessive use, as with alcohol, is not the way to personal well-being. The proposed action of the Federal Government to remove the drug from the Narcotics Control Act and assign it to the Food and Drugs Act makes good sense. The problem does not end there, however. Research and education are still required.

Marijuana should be recognized for what it is, an intoxicant whose use should not be entirely free, but also should not be a "criminal" matter, unless resultant behavior is in that category.

Prevention and Control

Prevention of drug and alcohol abuse can best be approached through education. The Smith, Kline and French (1967) book on drug abuse was specifically intended as a guide for educators and it is a very useful piece of work.

The Division of Alcoholism, in its present form, would disappear, if the reorganization of health services took place as recommended in Chapter 5. It would be replaced by a technical staff, concerned with both drug and alcohol abuse, and with responsibility for education, consultation with other health agencies and with the Health Commission and for the stimulation of research by way of liaison with the Human Resources Research Council. Education would be aimed in part at altering attitudes toward alcohol and drinking behavior, with the objective of reducing abuse of alcohol. In addition, educational efforts would be aimed at acquainting youths and others with the dangers of drug abuse of any kind and of addiction, in particular.

Agencies and services, which would benefit from the continuing advice of consultants on addiction, would include: community agencies which need help to plan rehabilitation programs; and municipal police who have a heavy and most unrewarding responsibility to assume in early contacts with the problem drinker.

The community service consultants of the current Division of Alcoholism perform a very necessary but limited function. That operation should be strengthened and extended to addiction generally, while the Division itself gets out of the business of operating treatment centres. The success rate of those centres probably does not exceed spontaneous remission anyway, judging from the record of similar operations elsewhere and unofficial estimates here. There has been no systematic evaluation of treatment programs of the alcoholism clinics, however, so no local data can be presented.

The Government should initiate cooperation with the Federal Government and other provinces to share planned research programs and to establish nation-wide, consistent policies and regulations relating to addiction of all kinds.

In all of the above, no distinction should be made between alcohol and other drugs. The same staffs should attend to both, in a planning and information service capacity at headquarters (in the proposed Commission), and in an operational role in the communities (as part of regional health and welfare units).

Control of drug abuse with addictive and habituating drugs also requires a high degree of cooperation between physicians and pharmacists and their respective associations in Alberta. Forged prescriptions and multiple prescriptions for one person from several physicians are two of the problems which require attention.

In a report to the Study Group on Addiction Mr. Walter L. Boddy, Assistant-Registrar of the Alberta Pharmaceutical Association made the following points.

1. Forged prescriptions on stolen prescription pads have been presented to Edmonton pharmacies for "problem narcotics". (N)

2. Another "problem narcotic" (N) has been chosen in break-ins of drug stores.

3. Large prescriptions for narcotic preparations, which are subject to less control ("oral prescription" narcotics), are often presented to pharmacies.

4. Physicians are "worked in various ways" to obtain prescriptions for another narcotic, which Mr. Boddy terms "a very frequently prescribed and abused preparation".

5. "Recent investigation showed that one patient went to five physicians in a three-month period and obtained (the same drug) from four of these physicians." Pharmacists have been warned to confirm the amounts of such prescriptions and to advise physicians about the possibility of abuse.

6. Pharmacists have also been cautioned to verify all "doubtful prescriptions" for controlled drugs (G) and prescription drugs (F). Forgeries have been detected in each case.

Mr. Boddy makes suggestions for both pharmacists and physicians, which are supported by this Study.

1. Physicians should not initial reportable prescriptions.

2. A physician's banking signature should be established and used on all narcotic (N) and other reportable drugs (G).

3. Sample signatures be made available from the College of Physicians and Surgeons via the Alberta Pharmaceutical Association to pharmacists having difficulty with signatures.

4. Physicians should be prepared to verify prescriptions promptly and personally by telephone when requested to do so by a pharmacist.

5. Pharmacists should exchange information with physicians on multiple prescriptions for drugs which are of concern.

6. A triplicate prescription be considered: one copy for the physician, one for the pharmacist and one for a central registry, in the case of drugs of concern locally. (This is a matter which involves professional ethics and would require approval of the medical profession. If the proposal were acceptable, the M.O.H. might be responsible for the registry. WRNB)

7. Pharmacists should maintain records by patients, on reportable drugs and oral narcotics and F drugs.

8. Pharmacists should exercise greater security over dispensaries, to avoid repetitions of the theft of drugs.

Research

The need for behavioral research to fill the scientific information gap in Alberta has again been revealed. Research is needed on every aspect of addiction: incidence, nature and severity of the problem; treatment methods; and effectiveness of programs of all kinds. In particular, there is a requirement for longitudinal research beginning at the acute stage (or before, if possible), instead of the usual cross-sectional studies, which do not establish primary and secondary influences or causes.

Considerable research is going on elsewhere but there is a responsibility to undertake a fair share of responsibility in Alberta. Local information is urgently needed to plan programs.

Consideration should be given by all concerned to the formation of a behavioral research institute at one of the Alberta universities, or possibly several planned to function in a coordinated manner and to undertake research on addiction, as broadly defined, and other mental health problems. Support could logically come from the Human Resources Research Council, because the conservation of human resources is definitely involved. Community support might also be expected, if the generally expressed concern to this Study about mental health is genuine.

RECOMMENDATIONS

It is recommended that:

1. The early detection and treatment resources of the school systems and guidance clinics should be strengthened and extended as one means of preventing and reducing addiction. All school divisions require pupil personnel services. Each of the proposed health regions requires a clinic.

2. The abuse of alcohol and the abuse of drugs should be treated as one problem and an aspect of mental health, in the development of services for detection, diagnosis, treatment, rehabilitation, prevention and research.

3. The delivery system, in the case of drug and alcohol abuse, should be the same as in other forms of mental illness and maladaptive behavior; that is, first, non-hospital facilities; then active treatment general hospitals; followed by longer term facilities or chronic facilities, if necessary (regional mental hospital); and rehabilitation services at each point in the system.

4. Detoxification of acute alcoholics should take place at general hospitals, not mental hospitals, with rare exceptions.

5. Special longer term facilities (half-way houses, boarding homes and rehabilitation camps) should be created with Government support and community participation.

6. Legislation should be enacted to provide for absolute and conditional discharge in relation to drunkenness, and possibly for drug abuse, too.

7. Marijuana should not be classed as a narcotic. It would be properly listed under the Food and Drugs Act. Much more information is needed about possible dependence on it and its part, if any, in the use of addictive drugs.

8. The replacements for the Division of Alcoholism should be responsible for plans, education and consultation regarding addiction generally, as staff members of the proposed Health Services Commission.

9. Continuing discussion and cooperation with the provinces and the Federal Government should take place to develop consistent policies and shared research programs related to drug and alcohol abuse.

10. Alcoholism clinics should be combined with guidance centres, health units and welfare facilities, on a regional basis, as health and welfare units.

11. Physicians and pharmacists should join forces, as proposed earlier in this Chapter, to improve control over drugs, which are of concern in the context of addiction.

12. A behavioral research institute should be established at one or more Alberta universities to conduct basic and applied research on drug and alcohol abuse and other aspects of mental health.

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CHAPTER 19

FORENSIC SERVICES

Section 1: Report of Dr. R.E. Turner, Consultant to Alberta Mental Health Study.

Section 2: Submission from the John Howard Society of Canada.

Section 3: Comments and Recommendations.

CHAPTER 19

FORENSIC SERVICES

REPORT OF DR. R.E. TURNER, CHIEF OF SERVICE, FORENSIC, CLARKE INSTITUTE OF PSYCHIATRY

Preamble

A White Paper on Human Resources Development, March, 1967, indicated the intention of the Government of Alberta "to provide active leadership in the objective reassessment of modern social and economic conditions, and in the development and advancement of new concepts and policies designed specifically for the dynamic new era of human achievement" for the Province. The "White Paper" recognizes that fundamental and comprehensive research is essential, in addition to desire and opportunity, as a prerequisite to the development of sound concepts and policies for the future.

It is noted particular concern about programs and facilities in two major fields of human care and rehabilitation:-

"(a) Programs and facilities for the treatment and rehabilitation of the mentally ill.

(b) Programs and institutions for the custody and rehabilitation of criminals."

Relevant to these special studies on mental health and penology is the statement concerning the progressive development of new medical sciences centres and to:-

"(b) Continue to improve its overall health programs in keeping with the most advanced medical knowledge, and progressively provide more and better facilities and skilled personnel for the diagnosis, treatment, care and rehabilitation of the physically and mentally ill."

These two areas of manpower and services for Human Resources Development are related conjointly to the recommendation for social rehabilitation services:-

"A new Forensic Clinic is being established.

The services of Family Courts will be made available in more communities.

Probation services for both juvenile and adult offenders will be extended."

"Forensic psychiatry is the application of psychiatry to legal problems, the accent being on psychiatry rather than law; psychiatric jurisprudence is primarily a branch of law. Forensic psychiatry is concerned with both criminal and civil law matters. A forensic clinic is designed to facilitate this application of psychiatry to legal problems."

OUTLINE

This report will consider the establishment of a forensic clinic in Alberta under the following headings:

Legislation
Referrals
Staff
Facilities
Location
Treatment
Teaching
Research
Relationships

LEGISLATION

Criminal Code of Canada

The sections of Criminal Code of Canada relevant to the operation of the forensic clinic are contained most frequently in the following sections:

S.16	Insanity
S.201	Murder
S.202A	Clarification of Murder
S.524	Insanity at time of trial
S.523	Insanity of accused when offence committed
S.527	Prisoner mentally ill
S.451	Remand of accused

Provincial Legislation

Provincial legislation should include a magistrate or judge's
(a) Order for Examination
(b) Order for Admission for Examination

The first applies for a person charged with or convicted of an offence to attend a forensic clinic for out-patient examination. The "Order for Admission for Examination" would be concerned with an in-patient psychiatric examination.

Provincial legislation should also provide authority for a judge or magistrate to order a person to undertake psychiatric treatment. Recent experience in Ontario indicates that it is legally possible for a judge or magistrate to order a person to attend a clinic for out-patient treatment. Legal opinion indicates that a person cannot be ordered for in-patient treatment in addition to a sentence being rendered. In-patient treatment must be arranged independently and not part of sentence.

Provincial legislation should have provisions to enable transfer of prisoners from jails and prisons and patients from mental hospitals for specialized forensic psychiatric consultation when required, unless it is agreeable that these transfers be informal.

It is not deemed necessary to have legislation permitting those on probation or parole or those with after-care agencies to attend a forensic clinic for examination or treatment if the clinic policy permits the acceptance of voluntary patients.

REFERRALS

A policy decision must be made at the outset whether forensic clinic is to accept only statutory referrals, i.e., orders of judges and magistrates, or whether the clinic will accept not only statutory referrals but those from the Crown and defense counsels. It is recommended that the latter be included in the referral policy. It is also recommended that both male and female persons be accepted.

A complete forensic psychiatric service would offer similar facilities for juveniles who appear before Juvenile and Family Courts. Because of the specialized nature of child psychiatry and juvenile delinquency, it is recommended that forensic psychiatric facilities for this group be somewhat separate from the adult clinic although related to it.

Because of the nature of the disorders due to alcohol and the addictions and the extent of this problem, it is recommended that these be considered separately although again in a related way to a central forensic clinic.

Reference has been made above to the inclusion of referrals from probation and parole officers, after-care agencies and transfers from jails and prisons.

At the outset, it may be necessary to restrict intake to selected sources and to expand as staff and facilities permit.

STAFF

A full-time staff is necessary consisting of a psychiatrist, psychologist and social worker with secretarial personnel. Because of the intricate nature of many of the problems within forensic psychiatry, the forensic clinic should have other part-time or consultant staff related to it such as internist, neurologist, lawyer, sociologist, and access to medical investigations such as electroencephalography, radiology and laboratory procedures.

FACILITIES

For a complete forensic clinic and service, two divisions must be considered - an out-patient division and in-patient division. A substantial proportion of referrals can be seen as out-patients but a number of beds for in-patient examination should be included (possibly 6) for the examination of persons requiring hospitalization and medium security. Although it is desirable to have both the out-patient and in-patient divisions in the same structure, it would be possible to have the two divisions separate with the in-patient division part of a psychiatric and mental hospital. It should be the policy that the staff of the in-patient beds should be regarded as full-time forensic personnel and part of the total forensic clinic.

If forensic services are extended to children, it is preferable that the children be separated from the adults if an in-patient facility is involved.

The forensic clinic facilities must not be remote from a parent institution such as a university hospital, psychiatric department, or mental hospital nor too remote from the main courts and legal and probation offices.

Persons, who are detained on Lieutenant-Governor's warrants, should be placed in a maximum security section of a mental hospital. Forensic clinic personnel would be involved with them in an advisory or consultative way rather than directly involved in their care.

LOCATION

Reference has already been made to the necessity for a forensic clinic to be part or adjacent to the main psychiatric and medical facilities of the area.

It is mandatory to have a formal association with a university and especially a medical school. This policy derives not only from the nature of the practice of forensic psychiatry but for the recruitment of responsible and experienced staff. The development, enlargement and success of the forensic clinic is dependent upon such a relationship.

The population distribution in Alberta is such that it is feasible for one forensic service to serve the northern half of the Province and the other to serve the southern half. The obvious locations would be in Edmonton and Calgary. At the outset, for practical reasons, it would be suggested that a forensic clinic be established in the capital city as a pilot clinic, adjacent not only to established medical school facilities and universities but to government. This should be followed as soon as possible with a second centre once recruitment of further staff is possible and policy is clarified by local experience.

TREATMENT

This is considered a separate item to emphasize the necessity of including treatment in the program of the forensic clinic. Experience elsewhere has repeatedly indicated that the success of a forensic service depends in part on the inclusion of a treatment program. This is based on the factors of service to the community, recruitment of staff, and research of the mentally and emotionally disturbed offenders which cannot be fully undertaken without a treatment program. This reduces the consultation and assessment service but, in the long run, offers a more complete and satisfactory program.

TEACHING

The inclusion of teaching is relevant also to a complete program and underlines the necessity for association with a university. Teaching extends knowledge and experience to undergraduates and psychiatric postgraduates and other related disciplines such as social work, psychology, nursing, law, and the various agencies concerned with corrections as cited above.

A probable by-product of the teaching program is to arouse the interest of professional persons for the correctional field and further recruitment of additional staff. Such recruitment would not only be the forensic service but for personnel in related correctional areas. Experience has shown that a staff of a forensic service can ultimately assume various senior positions in correctional agencies and departments.

RESEARCH

The "White Paper" emphasizes the need for a research at the outset. A great deal of research is necessary in the field of emotionally and psychiatrically disturbed offenders. Before more refined assessment and treatment methods can be developed, it should be the initial policy of a forensic clinic to include research, personnel and funds.

RELATIONSHIPS

There is also a requirement for continuing, close liaison between the clinic and personnel responsible for referral, care, after-care and discharge. Apart from periodic, clinical case conferences there should also be interdisciplinary seminars with the following participants: clinic staff, professional staff of the parent hospital, magistrates and judges, provincial probation service, lawyers, John Howard and Elizabeth Fry Society personnel.

SECTION 2: CHAPTER 19

FORENSIC SERVICES

THE JOHN HOWARD SOCIETY OF ALBERTA

1104 - 9th Street S.W.
Calgary 3, Alberta
October 25, 1968

Dr. W.R.N. Blair, Director
Alberta Mental Health Study
University of Calgary
Calgary 44, Alberta

Dear Sir:

May we express our appreciation for the opportunity to present and observations on the issues concerning mental health in Alberta. The appointment of your commission is evidence that the Alberta Government has become aware that mental health deserves serious attention.

The John Howard Society of Alberta was established in 1948 and has expanded to provide services throughout this Province. Its purposes encompass: a program for direct service, in which prison inmates are provided with assistance while undergoing sentence, and are helped to become re-established after release from custody; a public education programme in which staff and members of the Society interpret correctional problems; and a penal reform function which, through media and briefs, assists in throwing light on the inadequacies and strengths of our correctional programmes.

In the carrying out of our service function, we have developed working relationships with personnel in the Provincial and Federal correctional fields, in police departments, courts and juvenile services, adult penal institutions, probation and parole services. We have also worked closely with mental hospitals, guidance clinics, individual psychiatrists and the Canadian Mental Health Association. Within our agency we have developed citizen interest in the subject of corrections, and have obtained a marked degree of success in cultivating citizen support in the re-establishment of people returning to the communities after having been dealt with by the courts and the correctional process. From our experience, our members and staff have developed a body of knowledge and practise, equipping us to speak on the subjects of crime and delinquency with some competence.

In the thousands of cases we have handled, personality traits and behaviour characteristics have been observed, which if researched, could provide valuable information for use by all stages of correctional process.

The major concerns of the John Howard Society of Alberta have not traditionally been in the field of mental health. Nevertheless, individual, group, and community mental health have considerable bearing in our work in the field of corrections. We have been especially active in seeking the development of Forensic Services in Alberta.

Our view as to a primary purpose of Forensic Service is expressed in the following paragraphs quoted from our brief to the Ball Committee, presented on January 28, 1966--

> "We do not see the primary purpose of forensic services to Criminal Courts as being to assist in determining criminal responsibility. If such were the primary purpose, forensic services would simply add a refinement to legal procedures now aimed at determining which persons should be punished as willful wrongdoers, and which should be excused from normal legal consequences because of mental aberration or social disadvantage. It is our earnest hope that forensic services would not be misused or abused to help in 'getting people off'."
>
> "Often a crime is, in addition to a breach of the criminal law, a symptom of gross disturbance, portending aberrant behaviour in the future. A diagnosis from a Forensic Clinic would make such potential known to the Court prior to sentencing. The courts are becoming increasingly concerned with all aspects of sentencing and they need a more comprehensive range of diagnostic facts to assist in the task of sentencing. The court may well require, as a consequence of a forensic evaluation, that a sentence include treatment as well as punishment. The use of forensic services at the criminal court level has potential for prevention, if it offsets a repeat crime by the same offender, and thus his possible contamination of other citizens. It could also draw to the court's attention, behaviour which cannot be corrected, thus supporting a sentence to long term custody to protect society."

The worker and the volunteer in either the correctional or mental health fields, face problems which are similar and suggest similar problem-solving approaches. We will try to highlight some of these similarities and suggest that some of our experience in the corrections field may have relevance to the field of mental health.

General Considerations with Regard to Mental Health Services

1. We feel that communities and individuals of communities must be informed about the problems which exist, whether in corrections or in mental health. An honest public information and education program needs to be developed.

2. We believe that citizens must become involved as well as informed, through auxiliaries and boards to existing facilities, and through direct relationships with inmates and/or patients, helping them to find themselves in a social community. We submit that, as in "corrections", so in "mental health" programs, opportunities must be built in for community involvement.

3. Individuals ought to be encouraged to become interested in and to participate in the planning and development of services and this can happen at many levels of sophistication.

4. Following from this, while government must ensure basic service, the private citizen should be expected to contribute towards the resourcing of service, not only through taxation, but also through voluntary contribution.

5. Another consideration, in our view, is that not all services need be (nor is it necessarily desirable that they be) provided by the governmental agency. Some services can be provided by private organizations utilizing private resources, and contracting to the government to provide other services which traditionally were rendered by the civil service. This is desirable, not only as a means of increasing the participation in services, but also to increase the base of variety and vitality of problem-solving approaches.

6. We believe that the provincial government should develop financial incentives to communities to develop their own mental health programs and facilities as alternatives to committing individuals to large centralized institutions. A similar approach has been developed in some correctional systems with striking results.

7. Large institutions should no longer be developed. Institutions should not be located in isolated spots around the province. Locations should permit maximum contact with community (as opposed to institutional) living, and maximum use of scarce resources of personnel and research facilities. We would encourage the development of small facilities, working in close contact as part of a community complex of mental health services, developed as complementary to facilities for physical health, and where feasible, in connection with a university. The general hospital appears to us a logical "care" facilitiy to which such services may be attached.

8. Facilities need to be connected with universities to enhance research, to make maximum use of cross-discipline opportunities in the medical and social sciences and to be a maximum accessibility and use in the encouragement and training of practitioners in the mental health field.

9. Research into the causes, prevention and treatment of mental ill-health or the enhancement of mental health must have a primary and well endowed place in a program of service in this province.

10. Staff resources are admittedly scarce at all levels. Experience in other fields, say, education, has demonstrated that where encouragement and incentive programs are developed, adequate personnel resources develop. No program can be effective in matters of mental health which is under-resourced. There must be a frank recognition of the resource requirements. No approach which attempts to minimize this factor is either honest or desirable. In the long run the community will support an ample, well-resourced programme.

Some Specific Considerations in Regard to Mental Health Service in The Field of Corrections

By legislation and by practice, mental health services in the field of corrections are limited and most inadequate. Many of the victoms of this situation are inarticulate. Indeed, for all practical purposes, they are mute. As a result, the public is ill-informed about what services do exist, and exerts little pressure to improve the situation.

Practice seems to consist of the somewhat reluctant involvement of existing overtaxed mental health services in determining, for the Courts, whether some persons before the Courts are, or are not, fit to stand trial.

No problem-oriented, solution-seeking, diagnostic and differentiating information is available in the usual case before the Courts.

As well, persons may be transferred from provincial and federal correctional institutions to provincial mental health facilities under existing legislation. In practice, such persons must be "in extremis". There is virtually no intervention for persons with developing problems. Only persons who are actively psychotic (and probably actively disruptive of prison routine) are likely to be so transferred. Existing mental health facilities seem to be reluctant to receive such patients, and generally to feel ill-equipped to deal with them.

Facilities designed to cope with the criminally insane, such as Ontario's Penetang, are not available in Western Canada.

In the light of these comments, we submit that a mental health programme in Alberta should include adequate resources to service the field of corrections.

Consideration should be given to the following developments:

1. Necessary specialized facilities for the criminally insane, possibly in conjunction with adjacent provinces and the federal government.
2. Forensic Services should be developed for general use in the field of corrections and their use by the corrections field strongly encouraged, if not made mandatory. A more detailed submission on Forensic Service is contained in the attached Brief.[1] (Printed in Vol. 2).
3. Service to help individuals without requiring a full psychotic condition before help can be forthcoming.
4. Research directed specifically to the relationship between mental health and criminal behaviour.
5. Programs to stimulate the development of a pool of staff, qualified specifically in mental health in the corrections field.
6. A pool of case information gathered by agencies in either the field of mental health, or those of correction, to be accessible to appropriate staff in either field.
7. We submit that all of the considerations under the heading, General Considerations with Regard to Mental Health Services, above, have pertinence here.

Respectfully submitted

(signed)

Rev. R. Gay, Vice-President
John Howard Society of Alberta

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[1] Submission to Dr. J. Donovan Ross, Minister of Health, dated November 10, 1967, entitled "Forensic Services".

CHAPTER 19

FORENSIC SERVICES

COMMENTS AND RECOMMENDATIONS

It is entirely possible to improve upon Dr. Turner's modest proposal (Section 1) without much increase in costs. The physical facilities for a forensic clinic in Edmonton could be provided at the Alberta Hospital, Oliver. That institution meets the criteria specified, including an association with the University and the presence of full time staffs of specialists.

In addition, as stated previously, detention centres at other locations (Calgary, Lethbridge, Medicine Hat, Grande Prairie) could serve in a forensic role, employing mental health professionals from guidance clinics and psychiatric units of general hospitals.

Finally, another forensic service is present at Ponoka. The Alberta Hospital now assumes the function and could meet the criteria specified. Specialized forensic services could be made available throughout central Alberta from that location.

Both of the hospitals (Oliver and Ponoka) would require maximum security provisions for "warrant" cases but these should not be difficult to provide.

The main requirement is to train a few personnel in the forensic specialty. Postgraduate training in forensic psychiatry is available at the Clarke Institute now and undoubtedly a training attachment there for psychologists could be negotiated.

The John Howard Society submission points out another requirement, a facility for the criminally insane similar to the Ontario Hospital at Penetanguishene. They suggest that the adjacent provinces might collaborate in the creation of a facility. It is understood that the possibility has already received some joint consideration. It should be pursued.

RECOMMENDATIONS

1. Forensic services should be provided on a modest scale, but on a province-wide basis, at strategic locations, to comprise initially: Alberta Hospitals, Edmonton and Ponoka; and detention centres at Edmonton, Calgary, Lethbridge, Medicine Hat, and Grande Prairie.

2. Professional staff services should be provided from mental health facilities including mental hospitals (on a regional basis), general hospital psychiatric units and guidance clinics.

3. Training of a few professional staff in the forensic specialty should be started soon.

4. Interprovincial collaboration in the development of a western facility for the criminally insane should be explored actively.

CHAPTER 20

DIAGNOSIS AND TREATMENT

Section 1:	Differential Diagnosis of Mental Disorders
Section 2:	Treatment

CHAPTER 20

DIAGNOSIS AND TREATMENT

DIFFERENTIAL DIAGNOSIS OF MENTAL DISORDERS[1]

This section will attempt to present an outline of the present problems, constructive research, and future directions in the differential diagnosis of mental disorders.

Nosology

An increasingly large number of psychiatrists and psychologists are expressing dissatisfaction with the present classifications of mental illness, both on theoretical and practical grounds. Altschule (1967), in a discussion of the history, cause, and nature of schizophrenia, expresses the opinion that the term "schizophrenia" should be abandoned because it has too many variations of meaning. In the same vein, Karl Menninger has said, "Dr. A's 'schizophrenia' is different from Dr. B's 'schizophrenia'. And as long as we think of mental illness as a horrible monster with a name like schizophrenia - we won't be able to prevent it." (Hall, 1969) Towler and Wick (1967) present evidence that all patients suffering from "schizophrenia", do not have the same disease and, as could be expected, do not benefit from the same treatment.

Few attempts have been made to validate a new classification system. One of the most exhaustive efforts was a five-year study conducted by Harrower (1965). Over 2000 patients were seen for psychodiagnosis prior to treatment. Instead of disease labels, the author used a concept of "mental health potential".

Patients with high potential showed significantly greater improvement in therapy. The shift in emphasis from a negative to a positive view of a person's strengths and creative potential is to be welcomed.

Diagnostic Criteria

Another difficulty in differential diagnosis arises. On what basis is a diagnosis made? There are various criteria, such as test responses, overt behavior, the case history, difficulties in adjustment, and disturbance to family, community, or mental institution.

There is considerable evidence that statistical diagnosis and prediction are superior to clinical techniques. In 1954 Meehl reviewed the evidence for clinical and statistical prediction, and concluded that statistical prediction tended to be the more efficient method. In a later paper, Meehl (1959) compared the clinical judgment of 21 clinicians with five statistical methods in the identification of psychosis from MMPI profiles of a large sample of previously diagnosed neurotics and psychotics. The clinical judgements were the least valid, and individual clinicians varied significantly. Although this study presents obvious difficulties such as the utility of the MMPI as a source of clinical data, the assumption of a neurosis-psychosis continuum, and the validity of the previous clinical judgments against which these results were validated, statistical procedures were superior. These results received support in similar studies (Meehl & Dahlstrom, 1960, Lykken and Rose, 1963 and Goldberg, 1965).

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[1] Based on a report by Heather Wood, M.A., a research officer with the Study.

However, as Gough (1962) commented, "Although statistical modes of prediction at the present time seem to have surpassed the clinical ones in accuracy, neither procedure has done very well." (p. 573) . However, the use of objective data, numerically expressed and combined optimally clearly merits more attention in the development of differential diagnosis. (Astrup & Noreik, 1966; Harrower, 1965).

Various psychometric instruments have been reported to differentiate specific mental disturbances. For example, Foulds (1965) found that the Symptom-Sign Inventory differentiated types of psychosis and neurosis at a level higher than chance, and as well as psychiatric ratings.

Another diagnostic technique reported in the recent literature is based on clinical information. Wing et al. (1967) constructed a "present state" interview, with material derived from clinical practice and experience. Although still in the early stages, it has demonstrated satisfactory reliability, and appears to be an improvement on an unstructured interview.

In addition to diagnoses made on the basis of statistical indices, psychometric measures, and structured interviews, there is some evidence that physiological responses might be used to make differential diagnoses. Stern and McDonald (1965) reviewed the evidence for physiological correlates of mental disease. There were suggestions that different mental disorders are characterized by distinctive EEG patterns, electro-dermal responses, and biochemical measures. However, because of inadequate sampling and other deficiencies in experimental design and control, the results are not conclusive.

Zubin, (1967) sums up the case on diagnosis well. It is concerned with aetiology, prognosis, and the selection of treatment. The reliability and validity of all diagnostic techniques are too low. Zubin reviewed studies of reliability between observers and for initial and subsequent diagnosis. The results are poor, particularly for the functional psychoses. The validity studies were also disappointing; in particular, success in terms of essential predictive validity has been limited.

The Diagnostician

The bitter conclusion, to the study of who should make the differential diagnosis, is that this function is best left in the hands of the computer for the present. Numerous studies can be quoted which reach one conclusion, that the clinical judgment of the psychiatrist, psychologist, or both, regardless of experience, is unreliable and achieves a validity of slightly more than chance (Ash, 1949; Foulds, 1955; Goldberg, 1965; Mehlman, 1952; Schmidt & Fonda, 1956; Seeman, 1953; Zubin, 1967). It is also clear that the diagnostician is frustrated in his task by labels, which lack common meaning and usefulness, testing instruments which are seriously inadequate, and research evidence which is rendered undependable by the continued neglect of experimental controls.

Placement

Out of the vast literature concerning diagnosis, there is no consistent indication that clinical diagnosis can predict the appropriate placement of a mental patient, i.e. out-patient, day-care, acute treatment centre, or longer term care. David (1967) reviewed the literature concerning criteria of clinical change and measurement. He concluded that there was little general agreement and suggested that adequate, objective criteria must be developed in order to benefit patients and use resources fully. The one experiment in the recent literature, which reported significant results for a placement procedure, was conducted by Freedman et al. (1967). The Hospitalization Proneness Scale (HPS), an empirically developed scale designed to predict psychiatric hospitalization from a community clinic, was validated on two large groups of psychiatric patients. It was significantly related to hospitalization in the first group (.001 level), and in the two cross-validation groups (.01 level). It was also significantly associated with post-clinic adaptation, and return to treatment.

Treatment

Although experimental evidence does not strongly support the supposition that diagnosis indicates treatment validly, there are two recent studies which present encouraging results. Hsu and Yap (1967) suggest on the basis of their studies that measures of autonomic reactions may be useful as guides in choosing suitable drug treatment. Goldberg (1967) has presented evidence that improvement on each of four drugs was significantly related to measureable pretreatment symptoms. He used a large sample, random assignment of patients to each of the four phenothiazine groups, and a double-blind design. In the cross-validation of these results, improvement on drug treatment could be predicted .001 level. Both experiments are suggestive for further research, but they are not directly related to recovery.

Prognosis

There is some experimental evidence that diagnosis does, in some cases, indicate prognosis. Field and Miller (1967) examined case histories of a large group of schizophrenics in rehabilitation counselling using the Social Competence Index and the Elgin Prognostic Scale. The extremes of the distribution differentiated 42 process and 18 reactive schizophrenics. The diagnosis of process vs. reactive schizophrenia was significantly related to the number of interviews, and to discharge vs. discharge with success. Honigfeld and Gillio (1967) found a positive correlation between chronicity and increase of manifest symptoms of psychosis. The results were attributed to the hospitalization process.

Prognostic differences were found between newly admitted patients producing valid vs. invalid profiles and normal vs. abnormal profiles on the MMPI in a study conducted by Klett and Verstre (1967). However, only 28 per cent of the profiles were classifiable. Levinson et al. (1967) found that patients with a low score on the Authoritarian Patient Role-Conception Scale (APRC) had a significantly good prognosis, and those who were high on the APRC had a significantly poor prognosis.

The Hospital Adjustment Scale was used by Roback (1967) to predict discharge for 113 hospital patients. A 22-month follow-up investigation revealed that the initial adjustment ratings differentiated those patients who were discharged within the 22-month period, and those who were not capable of leaving the hospital for at least a week during this time. The results were significant at the .05 level.

The best that any of the prognostic studies, which were reviewed, can do is predict hospital discharge over a maximum time period of 22 months. Finer time distinctions, or interaction with different treatments can not, as yet, be predicted with accuracy. Among the new treatment methods, behavior therapy is the only technique that reports prognosis with any accuracy (Eysenck, 1960; Wolpe, 1958), and the prognosis here is related specifically to the treatment and not to diagnosis.

Deficiencies in experimental work in the area of differential diagnosis and prognosis are still as severe as when Fulkerson and Barry wrote their critique in 1961. There is still a need for larger, representative and homogeneous samples; for re-evaluation of the content and construct validity of psychometric instruments; for thorough and continuing validation and cross-validation of all tests employed by clinicians; and for studies which relate systematically treatment, duration of illness, and outcome to clinical, physiological and psychometric data, optimally combined.

In his report on the ten-year program outlined by the World Health Organization on social psychiatry, Lin (1967) describes four phases. The first would involve the standardization of psychiatric diagnosis, classification, and statistics. The second phase would be concerned with evaluation of phase one. The third phase would be concerned with extensive epidemiological studies of geographically defined population groups. The fourth phase would comprise formal international training in psychiatric epidemiology and social psychiatry.

Lin's program, which would be world wide, is attractive as a major goal but it is probably a long way off. It can be undertaken in miniature in Alberta, however, and the need here as a basis for the attack on mental illness is as great as it is in any other place. Action, which is indicated, includes an emphasis on operational definitions of observable behavior and measurable responses instead of current inadequate labels; the identification or creation of reliable criteria of change and recovery; the construction or adaptation of objective and reliable measures to improve the quality of differential diagnosis; and the painstaking validation of those measures with proper attention to sampling and other controls.

In other words, the requirement in Alberta in the context of diagnosis is for some straightforward research.

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SECTION 2:

CHAPTER 20

DIAGNOSIS AND TREATMENT

CURRENT TREATMENT PRACTICES: A REVIEW AND EVALUATION[1]

In a 1968 report of the Division of Mental Health to the Alberta Mental Health Study (Vol. II) methods of treatment employed in the mental hospitals of Alberta are described. They will be summarized by direct quotes now.

1. "From 1945 an electro-shock and insulin shock were used at both Ponoka and Edmonton and are still considered suitable treatment methods. There is a definite flexibility in treatment programs and occupational, recreational, and psycho-therapy, and modified insulin and electro-shock therapy are used as deemed most useful and beneficial in individual cases." (p. 25)

2. "Extensive use of the newly discovered tranquilizing drugs began in 1954 and 1955 with beneficial results. Not only are selected drugs used with patients in hospital but they are supplied as seems required to those treated as out-patients." (p. 25)

3. "In 1952, sessions in group therapy were instituted at the Alberta Hospital, Edmonton, and at about the same time at Ponoka...This form of therapy continues to be used. It has been found that used with other forms of therapy, there has been a marked increase in those allowed ground privileges and less destruction of hospital property." (p. 25)

4. With reference to leucotomies and the use of that method of treatment since 1952, the report states: "Over the succeeding years the number given this type of operation has steadily decreased. The procedure is still used on selected cases." (p. 26)

Other methods of treatment are not mentioned in the report and visits by members of the Study did not reveal much use of other methods. Alberta School Hospital (ASH) and Ponoka were exceptions. As mentioned earlier, ASH has an educational approach toward treatment of both retardates and emotionally disturbed children. Ponoka had introduced some excellent milieu therapy ideas, including a patient's council and a sheltered workshop. Other elements, although known to the staff, were only emerging slowly. The impression was that, if patient numbers were to become manageable, through staffing or reductions, the programs would follow shortly.

As observed, and as described by the Division, treatment methods, generally, within provincial mental health services are simply behind the times. There is no mention, and apparently little use, of milieu therapy and none of behavior therapy, the two most promising methods of treatment available today. Staffs in Alberta are not being trained in those techniques. Moreover, apart from a few notable cases, innovation is absent in the provincial hospital treatment approaches, which were observed. (One exception may no longer exist because the person responsible has left the service.)

Notwithstanding the absence of progressive treatment methods, persons in Alberta, who become mentally ill, now have a much better chance of recovery without long hospitalization than was the case before the introduction of anti-psychotic drugs. In the 1930's, admission with "schizophrenia" as a

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[1] Based on a report by Heather Wood, M.A., a research officer with the Study.

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diagnosis here and elsewhere was a life sentence for the majority. Now, about one in two hundred might be expected to remain in hospital more than two years. The "new" drugs (which appeared early in the 1950's) have made it possible to manage mental illness almost completely, while reorganization of disorganized thoughts, perceptions and behavior takes place, often spontaneously it is suspected without much more in the way of treatment being necessary.

Some of the treatment methods popular in Alberta will now be discussed briefly with reference to some experimental evidence.

Electroconvulsive Therapy (ECT)

Experimental evidence in support of ECT in the form of positive therapeutic results is negligible. Considerable negative evidence against its use is present. The latter evidence describes risks for some patients (Bodley and Fenwick, 1966); pre-treatment stress (Bolin, 1967) memory loss, confusion and motor disturbances (McAndrew et al., 1967). Schwartzman and Termansen (1967) compared ECT with other types of therapy and found it lacked superiority and had the disadvantages of physical complications and anxiety reactions.

Some professionals, while holding reservations about the method, claim it is a "life-saver" for seriously depressed persons with severe suicidal tendencies. Experimentation in that context obviously is confronted with difficult problems and limitations. With control and protection present, however, negative evidence relating to ECT indicates that other methods should have precedence. Costello and Belton (1968), after an extensive review of recent literature on the use of ECT with depressed patients, conclude that there is no good experimental evidence for its continued use.

The method's disadvantages point at least to the need to be most circumspect about using it. During the progress of the Study, the availability of ECT inside and outside the mental hospitals was raised. It was apparent that it is used quite extensively. It is considered that it should be used only under rigorous professional control and with awareness of the lack of experimental support.

Surgery

As indicated in the report from the Division of Mental Health, leucotomies are still being used infrequently with selected cases, (1968: 26). The method is viewed generally in scientific circles as a drastic and irreversible attempt to eliminate maladaptive behavior, by destroying the neural connections which sustain it. Almost always the behavior can be managed in another way.

Drug Therapy

This type of therapy is preferred by most practitioners and extensive evidence is available regarding its use. Positive results tend to predominate but, frequently, the experimental designs or samples, on which they are based, have been poor. A few results will now be mentioned.

Complete remission of symptoms was reported for 80% of depressed patients treated with iprindole compared with only 16% on a placebo by Daneman (1967) but there was no assessment of side effects and no follow-up. Complete remission of symptoms and release in the case of all male schizophrenics on chlorpromazine was reported by Hekimian and Friedhoff (1967) in a comparative study of small (N = 10) drug groups and a placebo group. Similar results were obtained with depressed patients by Haider (1967), using amitoriptyline and perphenazine.

Goldberg et al. (1967) studied the effects of four phenothiazines administered to two groups of 250 and 450 schizophrenic subjects. The subjects were randomly assigned, and a double-blind technique was used. The subjects' behavior was evaluated using clinical indices, the inpatient Multi-Dimensional Psychiatric Scale, and the Ward Behavior Rating Scale prior to and following treatment. None of the drugs caused regression in behavior, although some patients in the placebo group slipped back. It was found that those, who improved most, on each drug could be described in terms of their profiles of pre-treatment symptoms, using a linear, multiple regression analysis. Although side effects were not detailed, the experimental design was sufficiently rigorous to permit the conclusion that this study represents an important step forward in the attempt to discover drug treatments which are symptom-specific.

However, the evidence against the general efficacy of various forms of drug therapy, and against certain drugs specifically, is mounting. Hughes and Little (1967) speak of the toxic effects of chlorpromazine and newer preparations, which may not become fully apparent for years. They also object to the "questionable" practice of en masse administration of tranquilizers to long-stay patients, which they found to be continuing, and they appeal for an assessment of individual treatment needs and effects.

In support, Letermendia and Harris (1967) reported that the value of chlorpromazine in chronic schizophrenia was accepted without sufficient evidence of effect on different clinical conditions and that specific indications for its use had not been adequately explored. Hunter et al. (1967), Klein and Greenberg (1967), Keddie and Cooper (1966), all produce evidence, which indicates a need for more thorough validation of therapies specific to certain conditions and for caution and an individual approach in treatment.

A further reservation is expressed by Wahl (1967) in describing a condition, which he terms "status medicamentosus", a result of multiple, indiscriminate over-medication.

Many factors influence results in research on drug therapy, such as: sample size in relation to subject variability (Overall, 1967); pre-treatment anxiety level (Rickels and Downing, 1967); the prescribing doctor's attitude (Sheard, 1963; Uhlenhuth, 1966); the patient's attitude (Honigfeld, 1963); and drug absorption (Enoch, 1967). The problem of controlling for relevant factors is difficult and explains why much of the evidence is inconclusive. However, in this case, as in other aspects of mental health, Alberta has a stake in the outcome of the research and should be prepared to pay through local efforts or increased collaboration with others. In addition, all concerned should heed Engelhardt (1967) who argues that practitioners must be more alert to the problems of safety, toxicity and side effects. Helpful as they are, and they do represent a major breakthrough in terms of management as distinguished from treatment, the "new" drugs do not represent the end of the search. Moreover, social therapy and behavior management or modification comprise a major part of the solution to the problem.

Psychotherapy

The prognosis for psychotherapy as a useful and valuable form of treatment is discouraging. Bergin (1967) surveys psychotherapy research findings, and makes six conclusions from which implications are drawn for practice and research: (1) psychotherapy causes clients to become better or worse adjusted than controls; (2) controls improve with time as a result of informal therapeutic encounters; (3) therapeutic progress appears to vary with therapist's warmth, empathy, adjustment, and experience, all factors hard to measure or control; (4) client-centered therapy is the only interview-oriented method, validated by research; (5) traditional theories are seriously limited in effectiveness and are relevant to few disturbances; and (6) behavior therapies have considerable promise for enhancing therapeutic effectiveness, and should be utilized or experimented with more widely.

Pattison et al (1967) attempted to assess the therapeutic contribution of group psychotherapy to hospitalized patients. In comparison with a control group, patients in group psychotherapy did not show greater improvement, although both groups improved, on scales measuring ward behavior, psychiatric status, and self-perception.

Almost any form of verbal therapy appears to result in some improvement, usually small; but then improvement often results without treatment and to about the same extent. After decades of psychotherapeutic practice, little else can be said in defense of psychotherapy in experimental terms. Whether or not more ingeneous and possibly more specific methods for controlling and evaluating treatment will be devised, is an open question.

Milieu Therapy

Milieu therapy is based on the contention that hospitalization often reinforces deviancy, thereby encouraging a patient to be as sick as possible. In order to counteract the "hospitalization syndrome", the patient's total environment is used for its therapeutic effect, and the external situation is manipulated to provide consistency. Emphasis is on the patient taking more responsibility for himself through minor duties in patient administration, and work in hospital and community workshops.

As observed at Fort Logan Community Mental Health Centre, activity is the rule in milieu therapy. Group participation and interaction are emphasized to such an extent, at work, in discussions, and in recreation, that no one appears to have time or opportunity to indulge in withdrawal. This scene is in sharp contrast with mental hospitals in Alberta where "putting-in-time" often seems to be the major "activity". The hospital at Fort Logan has no locked wards; about one-half are locked in Alberta. Patients there are expected to cooperate in a responsible manner or leave; they tend to be detained in Alberta. They are reported to stay about 35 days on the average as residents; the median stay of those, who are released from Alberta hospitals, has been three to four months, as reported in Chapter 2.

A large number of studies report success with full or modified milieu therapy programs in mental hospitals. Three studies report improvements in behavior and an increase in the number of patients released from hospital, using aspects of milieu therapy such as group decisions, work therapy, and increased social contact outside the hospital (Faurbye, 1966; MacLennan & Levy, 1966; and Talbot & Miller, 1966). Gottesman (1967) described the experimental use of milieu therapy, with promising results for a five-month period, involving chronic patients who had been hospitalized for an average of 18 years, and had a mean age of 60. The experimental milieu provided a mixed ward, a sheltered workshop, which paid wages, a ward-run store, and a community-integrated rehabilitation program.

A similar project emphasizing responsibility, combined with group interaction and decision making, was effective with a large psychiatric ward of chronic male patients (Mason & Erickson, 1967). Individual ground privileges, cash allowances, passes, and steps toward discharge were based on the degree and effectiveness of the individual's acceptance of responsibility, as rated by groups of patients in combination with set standards and, in some cases, staff approval.

Positive results emerged from two additional studies where the main ingredients were a structured social setting with most tasks performed by patients. Brody and Finkle (1967) describe two short-term geriatric evaluation and treatment centres established in a private psychiatric hospital in order to prevent inappropriate mental hospitalization for aged patients. The centres guaranteed maximum 60-day hospitalization, with extensive individualization of programs. Of the original 148 patients, 70 percent were returned home, and 20 percent were capable of moving to nursing or boarding homes. These short-term milieu treatment centres cut the rate of entry to the state hospital by more than 50 percent. Cooper (1967) describes positive results with milieu therapy used in a hospital setting. In addition to higher rates of improvement and release, ECT was discontinued, and only reduced levels of tranquillizers were needed.

Among generally positive findings for milieu therapy there are some qualifying reports. In one, Greenblatt et al. (1965) compared a modified form of milieu therapy with drug therapy over a period of six years. Drug therapy was found to be more effective than milieu therapy without medication. However, when mild tranquillizers were prescribed, milieu therapy was effective, and the patients were more active and responsive. The method used was a conventional form of occupational therapy, casework service, and family participation. The results do not apply directly to the efficacy of more comprehensive forms of milieu therapy involving the other elements described above.

All of the experiments found in this review report partial to complete success of milieu therapy. There are two outstanding examples of hospital programs, which closely correspond to the ideal of milieu treatment, and illustrate the dramatic changes that result from a comprehensive effort. The first is the reorganization of the Weyburn Mental Hospital in Weyburn, Saskatchewan, described by Cumming and Cumming (1962) and by Lefave et al. (1967). With minimal changes in staff, facilities, or budget, an overall reorganization of the hospital program was effected along the lines of a therapeutic milieu. This was accomplished by re-educating staff and ward attendants, re-allocating authority, shifting the responsibility to the patient and, through the use of group experience, employing social pressure and control to bring about behavior change. The population dropped from 1519 in January, 1963 to 421 in June, 1966, and this rapid decrease in patients was largely attributed to the new program, which won the American Psychiatric Association Achievement Award. Although serious difficulty is still being experienced in drawing up satisfactory criteria for patient discharge (Frazier and Pokorny, 1967), the results are encouraging.

The second example, by Glasser (1965), comes from the Veterans' Administration Neuropsychiatric Hospital, Los Angeles, California. Glasser is the originator of "reality" therapy, which he is reported to have employed successfully with neurotics, psychotics, behavior problems, and persons of below average intelligence.

Reality and milieu therapy have the following similarities: (1) both therapies stress activity in the treatment of mental illness and reject the idea of a hospital as a passive institution; (2) both recognize the prime importance of the environment as a therapeutic agent and of social adjustment as the goal; (3) both place major responsibility for improvement on the patient, and direct therapeutic efforts towards producing more responsible behavior; (4) both require the patient to respond to conditions as they exist; and (5) the treatment programs have similar theoretical positions, as is evident by their use of graded increments of responsibility, patient participation in running the hospital, a "whole ward attitude" where everyone is involved and a general view of mental illness as an unacceptable mode of adjustment.

The program at Los Angeles Hospital for chronic psychotics began with the education of the staff in reality therapy. Regardless of status, they were assigned equal importance as therapists. Patients attended meetings with the staff, and placement in one of three wards was established. Glasser reports that 95% of the patients in the first experimental group of 160 were released from the hospital and at the time of the report had not returned.

The second program was conducted at Western State Hospital, Washington. Outstanding features of the milieu approach employed by that hospital were: group patient and staff decisions on all matters except medication; group pressure for more honest and better adjusted behavior; the requirement that the patient pay for treatment by undertaking essential work; earned privileges; and the responsibility to get off drugs as soon as possible. Out of the original 113 patients entering treatment in 1962, 99 were released by 1964.

From the evidence on milieu therapy in its various forms, it can be concluded that it is a useful form of treatment and probably has a promising future.

Behavior Therapy

Many treatment techniques are incorporated into the framework of behavior therapy. All are based to some extent on learning theory. A maladaptive symptom or behavior is the central issue, and the goal of treatment is the removal of the symptom or behavior from the person's repertoire of responses. The symptom may be as discrete as a facial twitch, or as complex as an anxiety reaction.

One form of therapy called "systematic desensitization" was originated by Wolpe and makes use of a method of relaxation outlined by Jacobson (1938).

The method is a practical application of drive conflict, where one response (relaxation) can inhibit another response (anxiety). By teaching the patient to relax in the presence or imagined presence of a series of anxiety-producing stimuli, arranged in increasing intensity, the patient reaches the point where the most intense stimulus produces no anxiety. This form of behavior therapy has been found useful in the treatment of neurotic maladjustments such as phobias, and other fear responses (Al-Issa & Kraft, 1967; Weitzman, 1967; Wolpe, 1967; Meyer and Crisp, in press).

Reinforcement has been employed successfully by behavior therapists in a variety of situations. Ayllon and Haughton (1962; 1967) report significant changes in eating behavior and verbal behavior of hospitalized, chronic schizophrenic patients. Schwartz (1967) developed social cooperation between pairs of schizophrenic patients using a reinforcement technique.

Details concerning the case for behavior therapy, the varieties of treatment techniques, the range of behavior treated, and the research studies carried out are presented in a number of books (Eysenck, 1964; Eysenck & Rachman, 1965; Krasner & Ullman, 1965; Wolpe, 1958; Wolpe et al., 1964). These reports suggest that the technique does produce positive changes, more quickly, in a measurable manner and to a more lasting extent than does psychotherapy. It even appears possible that some of the repetitive aspects of the therapy may not require a therapist. Lang is reported to have demonstrated that behavior therapy with neurotics can be programmed and can be effective without the presence of a therapist, (Eysenck, 1967).

Other kinds of behavior therapy include operant conditioning, which shows some promise even with chronic cases, and aversion therapy which may deserve another trial, under carefully designed and controlled conditions, with alcoholics.

Unlike some other forms of therapy, which lack an experimental foundation, behavior therapy continues to benefit from growth which is based on empirical findings. Laboratory research on behavior therapy is directly linked to real life situations and the prospects for modification in theory and practice appear almost limitless. But devotees must not relax and become another cult. They have much work to do if the promise of their early research is to be realized.

Gelder et al. (1967) point out that a single kind of behavior therapy can not be expected to apply to all patients in any category. Hoenig and Reed (1966), using psychogalvanic responses, found that clinical measures and self ratings may overestimate success of treatment. Some subjects responded physically to stimuli which, according to their reports, no longer aroused anxiety; thus indicating a need for more objective evaluation of effects. Costello (1967) points out that one operant technique may control maladaptive behavior or manage it but fail to to change it permanently. However, he also suggests that more sophisticated use of different kinds of reinforcement might increase resistance to extinction.

Several other problem areas are identified by Goodkin (1967). These are: creating more realistic response classes; getting objective measures of relevant variables; selecting appropriate behavioral modification techniques for each case; exploring stimulus conditions leading to the maladaptive behavior; and examining the carry-over of behavioral changes, produced in the experimental environment, to the natural environment.

The deficiencies found in behavior therapy point to the need for much more experimentation and validation of treatment methods and their long-term effects. However, the results reported by behavior therapists to date are impressive for certain specific conditions (eneuresis, tics, simple phobic conditions) and are promising for more complex neurotic and psychotic conditions.

The range of treatment, which should be available in Alberta today, would include improved use of drugs and comprehensive methods of milieu and behavior therapy and modification techniques, as indicated by empirical findings. Use of a complete repertoire of promising approaches to treatment, instead of the current restricted approach, should become an objective of the mental health program. Staffs should be recruited and trained to bring treatment practices here up to a modern standard and to improve them continuously.

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CHAPTER 21

RESEARCH

Committee

Chairman:	Dr. P.O. Davidson	Department of Psychology University of Calgary
Members:	Dr. T.E. Weckowicz	Department of Psychiatry University of Alberta
	Dr. J.T. Hamilton	Department of Psychology University of Lethbridge
	Dr. C.G. Costello	Department of Psychology University of Calgary
	Dr. J.R. Royce	Director Centre for Advanced Study in Theoretical Psychology University of Alberta
	Dr. K.I. Pearce	Head Department of Psychiatry Foothills Hospital Calgary

SECTION 1:	Report of Committee on Research
SECTION 2:	Conclusions of Alberta Mental Health Study

CHAPTER 21

SECTION 1 REPORT OF COMMITTEE ON RESEARCH

The committee is seriously concerned about the relative absence of mental health research in the Province of Alberta and the unfortunate implications this absence has on the mental health services of the Province.

Present Status of Mental Health Research in Alberta

In the period 1966-68, Alberta ranked seventh of the ten provinces (ahead of Quebec, Newfoundland and New Brunswick) in terms of the amount of research support (in dollars per capita and as a percentage of net revenue) for mental health from the Federal Government under the National Health Grants program. Alberta was also seventh in terms of absolute dollars of research support received. For comparison, during this period, when the Federal Government gave over $1,500,000 in support of mental health research, Alberta received $92,810 while our neighbouring provinces, British Columbia and Saskatchewan, received $279,300 and $216,550 respectively.[1]

Part of the reason for this serious discrepancy in Alberta's share of this Federal money undoubtedly lies in the failure of Alberta to forward a sufficient number of grant applications. The Research Committee feels that there are at least three reasons for this failure:

1. The Provincial Deputy Minister's refusal to forward to Ottawa, for consideration, grants which have been received by him from researchers in the Province of Alberta. For example, in 1967, over $85,000 worth of research proposals dealing with mental health problems, submitted by researchers from the Province of Alberta, were not even forwarded for consideration to the Federal Government. To the committee's knowledge, none of the researchers involved was ever advised why these applications were not forwarded so that they could modify them or resubmit them in a manner that would satisfy the Provincial Government.

2. Many researchers in the Province, who are both trained and experienced in doing mental health research, have been discouraged by what they classify as the Provincial Government's negative attitude to mental health research. When a researcher spends months very carefully preparing a research proposal, which he feels meets the criteria of the National Health Grants and then finds the following year that he did not receive that grant, because it was never even forwarded for consideration, it is not surprising to find him feeling discouraged. As a direct result of this kind of experience, more and more talented researchers are not even bothering to apply for National Health Grants in Alberta, but are shifting their research interests to other areas of the behavioural sciences and applying instead for grants from National Research Council, Defence Research Board, Medical Research Council, etc. This does not mean that the mental health research of the Province is being funded by other sources. It means instead that it is not being done.

   The net result of this problem is a vicious circle. The Provincial Department of Health can claim that it is not getting its share of Federal money for mental health research because the researchers are not submitting applications. But the researchers are not

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[1] All figures extracted from Research under the National Health Grants Program published by the Department of National Health and Welfare, Ottawa.

submitting applications because they have been discouraged about the possibilities of getting money for this kind of research.

3. The bitterness and disillusionment expressed by research workers to this Committee have unfortunately also been expressed to their colleagues at professional meetings, etc., with a result that Alberta is probably developing a reputation in Canada as a backward province in the area of mental health and certainly not a place to go if one is interested in doing research in mental health. Consequently, it is difficult or impossible to attract competent mental health researchers to Alberta (or even keep the ones that are here) and the net effect is to further inhibit the possibility of obtaining new research grant submissions for study in the field of mental health.

The Research Committee would further like to point out that the situation vis-a-vis National Health Grants certainly does not present the entire picture regarding mental health research. For example, the Province of Ontario, which received over $400,000 for mental health research from the National Health Grants in fact spent over $1,200,000 on mental health research during the period, 1966-68. The difference of over $800,000 was made up by that Province through the Ontario Mental Health Foundation. In 1968-69, the Ontario Mental Health Foundation budgeted for over $960,000 to support research grants and an additional $270,000 for research scholarships and fellowships. They expect to recover less than $220,000 of that amount from Federal sources.

The research situation in Alberta is consequently far worse than the National Health Grant figures would indicate, because Alberta has provided practically no additional sources of funds for mental health research.

Implications of an Active Research Program

Good business procedures require any ongoing operation to put some funds back into research, even if they accomplish nothing more than to provide a continuing examination of the efficiency of the activities undertaken by the organization. Other specific examples of the importance of an active research program in mental health follow:

1. Recruitment and Staffing
   Competent people in any area of specialization prefer to work at the forefront of their discipline. In the rapidly changing field of mental health, this almost necessitates that they either are directly involved in research themselves or are attached to a centre where research is an important part of the program. Staff morale tends to be much more positive in centres, which are research oriented, not specifically because of particular research projects, but because of the attitudes engendered in the staff that they are making progress in solving problems in the treatment and care of mental illness and are not merely marking time awaiting the progress to be made in some other centre. This positive attitude and good morale undoubtedly have a direct effect on the quality of patient care given by such staff.

2. Staff Training
   There is both a built-in and an indirect benefit of research on staff

training. In institutes, which have an ongoing research program, the staff is of necessity kept constantly informed of what results it is having. Thus, the staff becomes aware of new treatments or procedures by experience with them rather than by accidentally running across them in a journal article several months (or even years) later, assuming that the staff has the time and opportunity to search the research journals.

An indirect effect of active research support occurs at the university level of training, particularly in psychology. Since the Master's and doctoral degrees both require a research thesis, a student is more apt to specialize in mental health if there are staff interests and funds for research in that area. It is unfortunate that Alberta, with four large graduate departments of psychology, is turning out very few psychologists oriented toward working in the mental health field. The Research Committee has concluded that one important factor is the lack of research funds in mental health. As a result, many staff members who could and would train their students in mental health fields, have switched instead to emphasizing other areas of psychology, where money is more readily available. Graduate students are led into these areas by the staff interests and availability of funding, with the consequence that many students who are interested in mental health careers either go elsewhere for their training, and usually do not return, or they switch their area of interest in order to attend university in Alberta.

3. Evaluation of Programs

An important aspect of any research program is an evaluation of current procedures and a willingness to try and establish improved procedures. This on-going re-evaluation effects change and improvement in the system continuously and painlessly, thus avoiding the need for outside pressure for change. For example, a constant self-evaluation research program might easily lead to earlier changes and improvements, which would have lessened the urgency of the present study.

4. Mental Health Knowledge

Finally, it should be emphasized that in the field of mental health, there are no final answers, and often there are not even good initial answers, to many of the problems of treatment. Consequently research in this field should not be considered a luxury but a necessity.

RECOMMENDATIONS

1. Support for mental health research should be made available from the Province of Alberta through the Human Resources Research Council.

   It is suggested that serious consideration be given to allocating a separate sum for mental health research.

2. Regarding the amount of money to be supplied, the Committee hopes that the Province of Alberta will consider adopting the policy currently employed by the Province of Ontario.

   To quote Dr. Dewan, Executive Consultant to the Ontario Mental Health Foundation:

"The principle that all mental health research of high quality should be supported was accepted. The sole reservation of the Department of Health (of the Province of Ontario) was that the amounts they were prepared to give would be dependent on the resources of the Province. This policy has continued to the present; the government honoring all recommendations for support plus the amounts for fellowships, special lectureships, research and educational associateships, etc. Over the years, the number of applications has increased as general interest and the number of research personnel increase. The government apparently accepts this as a healthy development. To date, the question of the ratio of research allocation to overall mental health expenditure has not been raised."

3. The allocation of money for mental health research should be determined through the assistance of an Advisory Board on Mental Health Research.

   This Advisory Board would consist of personnel having demonstrated research capabilities and experience in the mental health field. The Advisory Board, operating under the present terms of reference of the Human Resources Research Council, would as part of its duties ensure that all mental health research proposals were evaluated competently and fairly.

   In addition, it would be responsible for ensuring that research programs under its aegis were relevant to the needs of the Province of Alberta and would, if necessary, initiate research programs or contract research that it deemed necessary.

4. Part of the responsibility of the Advisory Board would be to encourage and improve the training of research personnel in the mental health field and a proportion of its budget should be expended in supporting this aim.

5. The Chairman of the Advisory Board should be appointed as a member of the Human Resources Research Council in order to ensure that the mental health needs of the Province of Alberta have a voice in the policy decisions and budget allocations of the Council.

CHAPTER 21

RESEARCH

SECTION 2 CONCLUSIONS OF THE ALBERTA MENTAL HEALTH STUDY

Throughout this report deficiencies in information about mental health in the Province have been mentioned, many of which could have been avoided or could now be corrected through research. In addition, there is a requirement for Alberta to take part in the scientific search for solutions to general problems in the mental health field. The Government through its White Paper on Human Resources is committed to a policy of conserving and developing human resources. Mental health research clearly qualifies as a logical recipient of a good portion of the funds available to the Human Resources Research Council.

It is of concern, therefore, to note that the Council may be narrow in its research frame of reference and may become only a bureaucratic venture. In its Prospectus 1969-1970, p. 15 it announces:

> "Accordingly, we envision a research organization which is structured, in part, on the foundation model (inasmuch as it incorporates mechanisms for supporting selected inquiries by independent scholars); in part, as a contracting agency (inasmuch as it looks beyond itself for the research talents and expertise that it requires); and, in part, an in-house R and D centre (inasmuch as it includes an in-house capability for the conduct of certain kinds of research-development-planning-dissemination activities).

Support for this organizational model is quite adequately expressed in other parts of the document and the model is considered entirely appropriate by this Study. However, the Prospectus reveals little recognition of mental health as an area of interest (See page 18, in particular). It appears limited to educational subjects and problems. As indicated in Chapter 7 (Pupil Personnel Services), participants in this Study also assign high priority to the same field and these comments are not intended to detract in any way from that emphasis. It merely seems strange, and worthy of mention, that no examples or references to the important topic of mental health could be found in the Prospectus. If the Council is to be exclusively concerned with education, and related welfare and economic subjects, possibly it should be renamed.

Another reservation relates to the "in-house R and D centre" (p. 15 of the Prospectus). Unquestionably, in-house research is necessary if work is to be done which must be done, regardless of individual research interests. In addition, there is a demonstrable need for planning and programming other research and for the dissemination of information. In short, it is agreed that there must be an "in-house" development. It is submitted, however, that it should be of modest size. The staffing set out in the Prospectus suggests that it will be quite a bit larger.

The inference, which is drawn, unless funds are unlimited, is that an important research resource may not receive the attention it requires and merits. Reference is made to the "creative researchers" (p. 14 of the Prospectus) who tend ~~to be~~ found in other "houses", notably in universities. These are the persons~~, in the view of~~ this Study, who are most likely to produce findings of major significance. The Government, through the Council, has an opportunity to sponsor research in a vital area and also to contribute in yet another way to the development of first rate universities in the Province. Training of more researchers, through financial aid for graduate students, and the attraction and retention of superior academic staffs are several additional benefits which would accrue from the support of research at universities, in contrast with "in-house" activities of the Council.

Some of the more important topics for mental health research in the Province will be summarized now.

1. The incidence, nature and treatment or management implications of mental illness and maladaptive behavior in the population at large. Information is needed particularly for children and adolescents.

2. The evaluation of the effectiveness of treatment programs.

3. Etiological studies of all experiential and behavioral disorders on a wide front (psychological, biochemical, social).

4. Basic research aimed at fundamental and far-reaching development of better assessment, treatment and modification procedures.

5. The evaluation of training programs in the health professions.

6. The study of aging on an interdisciplinary basis aimed at utilization of talent, enrichment of the lives of older citizens and identification of special problems and solutions.

7. A pilot project on social and preventative psychiatry, the object of which would be to identify social problems that may lead to mental illness.

Topics #6 and #7 have been outlined to the Human Resources Research Council previously by the Chairman of the Study Group on Research.

RECOMMENDATIONS

1. Research on aging (Topic #6, above) should be the responsibility of an Alberta Institute on Aging, which should be established with support from the Human Resources Research Council at the University of Calgary. The initial financial support should be not less than $75,000 annually for a five-year period. (This project is already in a planning stage and has been documented.)

2. Subject to satisfactory documentation, it is recommended that a project on social and preventative psychiatry (Topic #7, above) be supported by the Council at the University of Alberta with a grant-in-aid to be negotiated.

3. Topics 1 - 4, inclusive (incidence, treatment evaluation, etiology and therapeutic methods), should be sponsored by the Council through similar grants-in-aid to scholars at Alberta universities and provincial institutions and as institutional grants to Alberta universities. A sum of approximately $150,000 should be made available in the first year for that purpose, to be divided according to advice from the Universities.

4. Topic #5 (evaluation of training programs) would be studied appropriately through in-house research of the Council if care is taken to ensure objectivity and independence.

5. It is also recommended that a residency in research for two psychiatric residents at $12,000 per year be established; that five research fellowships for Master's and Ph.D. students in psychology at $5,000 a year be created to support graduate students who wish to do research in the field of mental health; and that two research fellowships at $5,000 per year for Master's and Ph.D. students in sociology and anthropology or social welfare, be established to support graduate students who wish to do work in the same field.

6. All recommendations recorded in Section 1 of this Chapter have the full support of the Alberta Mental Health Study.

Very little money is now available from universities or outside sources to encourage graduate students to specialize in the area of mental health. The following quotation from the report of the Division of Mental Health to the Study (1968) will be of interest in that regard:

> "The Director of the Division of Mental Health has been provided with $10,000 in the last two years to initiate research projects in Alberta Guidance Clinics, Alberta Hospitals and in collaboration with the Departments of Psychology, University of Alberta, and University of Calgary." (p. 82).

REFERENCES

Division of Mental Health, Province of Alberta, Report to the Alberta Mental Health Study, 1968.

Human Resources Research Council, Prospectus 1969-1970, Edmonton, 1968.

CHAPTER 22

RESPONSIBILITIES AND COSTS

It was submitted earlier in this report that governmental and community responsibility toward personnel currently classed as mentally ill is to regard them and provide treatment for them in the same manner as persons with any other kind of illness. The quality of treatment and its availability should not be different for different diagnoses.

The information reported in this Study can lead to only two conclusions. The mentally ill in Alberta are in an underprivileged position now; and, second, the discrimination against them must end.

If there is any doubt about the inequality of services and treatment, an examination of the chapters in this report on disturbed and handicapped children (Chapters 12 and 13), pupil personnel services (Chapter 7) and patient care (Chapter 3) would provide the necessary substantiation. One particular disparity, which should be recognized, is the lack of readily available care for persons outside the two large cities.

Costs of mental health services are certainly important but they should be considered against the present background of inequality of treatment and regional disparity.

The new delivery system, proposed in this report, involves the maximum use of psychiatric units in general hospitals as the primary hospital facility. An addition of a psychiatric ward, floor, wing or unit as an integral part of a general hospital would cost no more than the addition of any other kind of ward. In addition, there is nothing to be saved by building a separate mental hospital, as compared with building a psychiatric element of a general hospital. Indeed, it is probable that there would be a saving in the latter case. However, the issue of general hospitals as a place of treatment, compared with mental hospitals, has been established on other grounds and should not require further discussion.

Per diem rates for hospitalization in all kinds of hospitals differ considerably and no attempt will be made here to assume the role of a cost accountant. The concern of this report is with principles and systems; detailed costing will have to be done by somebody else.

However, it should be observed that the cost of hospitalization in mental hospitals in Alberta is about $9.50 per day, on the average. General hospital costs for a patient in psychiatric units may approximate $35 per day on the average. Although it costs about four times as much per day for hospitalization in a general hospital, the average stay of a person, who is treated in a general hospital for mental illness, is relatively short, from one-third to one-quarter of the time of the average stay in a mental hospital. Therefore, it would appear that a balance between costs of the two types of treatment may exist, at least when mental hospital figures are restricted to cases released early.

Some mental hospital patients, of course, remain in hospital a long time. According to figures provided by the Division of Mental Health, 21 percent of patients remained over three months in 1967 at the Alberta Hospital, Edmonton; 38 percent was a comparable figure for Ponoka in the same year. The average length of stay in Alberta mental hospitals, of patients resident there in 1967, was 77 months. The average stay of patients at the psychiatric unit of the Foothills Hospital in the same year was 25 days. It would take a good deal of accounting to prove a case on one side or the other but it does appear that psychiatric units probably enjoy a favoured position if all patients hospitalized for mental illness are considered in the calculations.

Apart from the matter of cost, it should be recognized that a longer stay, which is generally associated with treatment in a mental hospital, has a deleterious effect on ultimate rehabilitation. An employee may lose his job during the longer term. Home life and social interrelationships are interrupted by lengthy periods of hospitalization. The released person is slower in returning to a productive life. It is obvious that a shorter stay in hospital will involve less disruption of a person's working, family and social life and will probably reduce the overall expense of treatment and rehabilitation.

Two examples may be cited. In Illinois, the average stay in psychiatric units of general hospitals is reported to be 16 days. Although the per diem costs are as high as $35 per patient per day, the total cost per patient has been approximately one-half of the total cost per patient treated in the State mental hospitals in Illinois. Second, Georgia has supported psychiatric units in general hospitals in its major cities since 1960. Although the daily cost to the State has been high ($30-$35), the cost per patient treated has been considerably less than the cost of long term treatment in the 12,000-bed State hospital at Milledgeville.

The distinction between treatment in the two settings, which is implied in the above observations, is that intensive treatment tends to be provided at general hospitals as a rule but that is not generally the case in mental hospitals. The financial advantages of intensive care have been well established. In three Washington State mental hospitals, which shifted from custodial care to intensive treatment, during the period 1954-64, the net reduction amounted to one-quarter, primarily through reduction of capital costs.

One of the important means of reducing costs is the provision of appropriate rehabilitation. The Veterans' Administration in the United States has estimated that $1 invested in rehabilitation of disabled veterans, who were returned to the labour force, returned $36 to the economy of the country. Good rehabilitation programs reduce readmission rates, increase institutional potentialities for more intensive care (through reduced patient populations) and reduce costs overall. The psychiatric home care program of the University of Saskatchewan Hospital is reported to cost $2 per patient. The program has been successful in maintaining, outside hospital and at a productive level, persons with histories of repeated breakdowns and long treatment. The provision of home care in this instance has reduced the length of stay in hospital and has obviously effected financial savings.

The possibilities for new approaches to intensive treatment and rehabilitation have not received sufficient attention in Alberta. When proper attention is assigned to them, at all levels from community to Provincial Government, overall costs of care should be substantially reduced. One type of care, which should be extended, is termed day-care. At Fort Logan Mental Health Centre in Colorado, the average cost per day for in-patient care is about $20; day care costs only $8 and out-patient follow-up care costs $8 per week. More programs of that kind are required to keep costs within reasonable bounds.

Another promising area of cost reduction is in the field of prevention and early treatment in non-hospital facilities. The first echelon of care has been discussed fully in previous chapters and will only be mentioned now. Coordination of currently competing and overlapping elements of that echelon is essential to economical operations. The solution, which has been proposed, is a major reorganization of health services (Chapter 5).

It is estimated that the six to eight million dollars which would have been spent on the proposed community mental health centre in Calgary would go a very long way toward financing the more urgent requirements in the Province. These are: more professional staff in the Public Service (with improved remuneration) to provide better programs; a psychiatric unit at each of Grande Prairie and Lethbridge Municipal Hospitals; improved facilities at the Children's Hospital in Calgary to help provide longer term care for emotionally disturbed children and adolescents; facilities for the treatment of children (acute cases) at the Foothills Hospital in Calgary; expanded psychiatric units in the general hospitals in Edmonton and Calgary; minor modifications at Oliver and Ponoka; and modification to Henwood to make it a suitable facility for emotionally disturbed youngsters.

The money saved on that one facility, which is not required in the new delivery system, possibly would meet all of the urgent requirements.

The guide lines for proper use of mental health funds at this time should be:

1. To avoid hospitalization by early detection and treatment in non-hospital facilities, wherever possible.

2. To reduce necessary hospitalization to the shortest possible period consistent with effective treatment.

3. To rehabilitate as fully as possible, immediately after treatment.

The delivery system proposed in this report would meet those criteria. The old system falls far short. The new system may cost more but that possibility, in the long run at least, appears remote. If the cost is greater, it must be borne to the fullest practical extent in the interest of maintaining equality of service for all.

CHAPTER 23

RECOMMENDATIONS

INCIDENCE

1. The Province of Alberta should not plan on building any more mental hospitals now or in the foreseeable future. The two large mental hospitals should be reduced to manageable size, while more appropriate facilities are provided in general hospitals.

2. Increased use should be made of psychiatric units in general hospitals, day hospitals, out-patient departments, guidance clinics and other non-hospital facilities.

3. The Province should support the establishment of more community facilities to provide social services for patients and families. Patient care could then be carried out on an active community basis, rather than requiring a large number of long-term hospital beds. The provision of half-way houses, boarding homes and sheltered workshops, to mention only three possibilities, is a more effective and more economical way of achieving maximum development of people, with dignity, than the continued extension of the mental hospital system.

4. The Government of Alberta should institute and maintain a computerized information system with relation to mental health which would provide the necessary basis for sound planning and program evaluation.

5. Research should be sponsored and conducted in force to determine the incidence, nature and treatment or management implications of mental illness and maladaptive behavior in the population at large.

PATIENT CARE

6. Admission practices in mental hospitals should be changed to ensure that all illness which can be treated within a general hospital will receive attention there and not be allowed to become a responsibility of a mental hospital.

7. Drug and alcohol withdrawal and detoxification should be carried out in general hospitals as a widely enforced rule. Referral of acute alcoholics, in particular, to mental hospitals should stop.

8. A concerted effort should be made to reduce the present populations of mental hospitals as other more appropriate community facilities are created or developed.

9. Staff shortages should be regarded by the Government as having passed a critical point. In the interest of meeting the need for improved patient care it is urged that energetic and sustained recruiting efforts be undertaken to build adequate staffs and to maintain them.

10. Mental health must be totally incorporated within the general health field in all respects.

11. The standard of general medical care in the mental hospitals must be greatly improved. Preventive health measures (routine chest films,

Papanicolau smears, urinalyses) are required; drug controls, based on general hospital accreditation standards, should be introduced.

12. More facilities, other than "active treatment" mental hospitals, must be developed for confused, old people. The extension of facilities, such as high quality chronic nursing homes, is indicated.

13. Institutions, which are primarily educational in nature, should become the responsibility of the Department of Education, instead of the Department of Health.

14. Responsibility for recreation and education within mental hospitals should involve the Department of Youth and Recreation and the Department of Education, to whatever extent is necessary to improve upon present unsatisfactory services.

DELIVERY SYSTEMS

15. It is recommended that the new delivery system proposed in Chapter 4 of this report, pages 38 - 49 be approved and introduced at the earliest possible date.

ORGANIZATION AND ADMINISTRATION

16. It is recommended that a new organizational and administrative structure be developed as a first step in the creation of a new program of mental health services for Alberta.

17. The principles, guidelines and organizational structure described in Chapter 5 should be given full consideration in that development.

18. Action should be taken to coordinate the work of health-related departments and establish priorities for them in a more effective way than is evident now.

19. It is further recommended that professional management consultants be employed in the implementation of recommendations Nos. 16 and 17, above.

MANPOWER FOR MENTAL HEALTH, EDUCATION AND TRAINING

Psychiatrist

20. In order to attract psychiatrists in urban areas to serve in the mental hospitals the administration of those hospitals should be so changed as to enable the psychiatrists to practice in the same style as is the tradition in the community and in the general hospitals.

21. For the Alberta Hospital, Ponoka, to be made more attractive to more psychiatrists, its function should change to that of a community hospital, a hub from which mental health services are distributed widely throughout the surrounding region.

22. Influence should be brought to bear through the Alberta Psychiatric Association and the University Departmentsof Psychiatry to change the role of psychiatrists traditionally practising privately as therapist-practitioners to that of consultant to other professional personnel, particularly to family physicians.

23. For purposes of recruitment the Government should establish a new organization responsible for a vigorous publicity campaign, such as a Department of Development and Human Relations.

24. Care should be taken by the College of Physicians and Surgeons of Alberta to eliminate unnecessary restrictions on eligibility and to develop good public relations towards psychiatrists and prospective trainees from elsewhere enquiring about the opportunities in Alberta.

25. Insofar as the Provincial Mental Hospitals and Guidance Clinics need to engage psychiatrists on salary, the salary schedule will have to be greatly increased to be competitive with psychiatrists' income from private practice.

26. Most of the psychiatric staff requirements of the mental hospitals and guidance clinics should be met by engaging psychiatrists on the basis of fee-for-service as prevails in the practice of medicine generally.

27. The Provincial Mental Hospitals and Guidance Clinics should be prepared to establish as many positions for psychiatrists in training as are enrolled in the graduate training program in the University of Alberta.

28. To divert potential manpower into the specialty of psychiatry the medical schools should ensure that undergraduate medical students are properly oriented towards the relative needs of the community for psychiatrists, and the Departments of Psychiatry should intensify its efforts to encourage graduating students towards the specialty practice.

29. Attractive professional training grants in adequate numbers from whatever source, or any alternative means of extra financial inducement, should be made to medical students preparing for their specialist qualifications in psychiatry.

30. The graduate training programs in psychiatry should be modified to ensure that the trainees are prepared for the changing role of psychiatrist towards that of consultant to the family physician and various professional personnel rather than simply that of therapist-practitioner.

Family Physician

31. As a means of increasing incentives for family practice with its important bearing on mental health care the College of Family Practice in Alberta should be given all possible encouragement and support in its endeavours to improve the image and enhance the status of the family physician.

32. The medical schools of Alberta should undertake the responsibility of making clear to medical students the particular importance of family practice.

33. All necessary encouragement and support should be given to teaching hospitals in establishing administrative departments of family practice and to faculties of medicine in establishing Chairs of Family Practice.

34. Special professorial training grants should be offered to medical graduates undertaking postgraduate study to qualify for the teaching of family practice.

35. The university faculties of medicine should be urged to ensure that in the training of general physicians they are given a firm grounding in the basic behavioural sciences, psychodynamics and psycho-social medicine.

36. The university faculties of medicine should immediately plan to offer postgraduate courses in psychological medicine for practising physicians, and for this purpose they should be offered special grants.

37. Grants-in-aid should be offered to physicians taking postgraduate courses in psychological medicine.

38. The university faculties of medicine should be urged to offer to family physicians substantial programs of continuing medical education in psychiatric care.

Psychologist

39. All necessary encouragement and support by the Government should be offered to the departments of psychology at Alberta universities to introduce or extend programs for the preparation of psychologists to practice in the mental health field.

40. The universities should be encouraged to offer training programs in psychology as preparation for the professional role of psychometricians or psychological technicians at the baccalaureate level.

41. Levels of remuneration for psychologists serving in the mental health facilities of the Provincial Government should be raised to be competitive with those offered in academic settings and private agencies.

42. More attractive professional training grants should be made available for university graduates specializing in clinical psychology.

43. A position for a senior psychologist at the doctoral level should be provided in each of the Provincial mental hospitals and major guidance clinics for supervisory and educational purposes.

44. A post of Advisor in Psychology to the Department of Health should be created and filled by a senior psychologist with both clinical and relevant research experience.

45. Amendment should be made in the "Psychologists Act" to make a doctoral degree in psychology the minimum legal requirement for a psychologist functioning independently in private practice.

46. The university faculties of education, through their counsellor education programs, should provide more ample basic courses and "continuing education" courses for school counsellors.

47. The universities should intensify their training programs for school psychologists.

48. School Boards should make provision for employing a greatly increased number of school psychologists.

49. The grant and subsidy policy of the Department of Education should be broadened so that the services of psychologists would be extended to all schools in the Province and should not be confined to those psychologists who hold a teacher's certificate.

Social Worker

50. The opportunities for professional social workers should be widely and intensively publicized through the Public Information Service to high school graduates and to baccalaureate university graduates.

51. More conducive professional training grants should be offered to university candidates proceeding towards their social work qualification.

52. The establishment for social workers at the two Provincial Mental Hospitals should be, as a first step, increased to at least 12 each, to be deployed predominantly in the follow-up care of patients discharged from the hospitals.

53. Vocational training programs for social work aides, child care workers and welfare workers should be encouraged and supported.

54. Wherever social work aides and welfare workers are employed in mental health services they should be under the direct supervision of qualified social workers.

55. A social worker consultant of high qualifications and wide experience should be appointed to the Department of Health to organize a recruitment program for social workers and social work aides to make for the optimum utilization of their skills.

Nurse

56. A post-basic program in psychiatric nursing should be offered by the School of Nursing at the University of Alberta.

57. The University of Alberta, in conjunction with universities in other western provinces, should develop an advanced psychiatric nursing program at the Master's level.

58. Special inducements should be offered through attractive grants and bursaries for registered nurses taking postgraduate courses in psychiatric nursing either in Alberta or elsewhere.

59. The present 3-year psychiatric nursing programs offered at the two Provincial Mental Hospitals should be condensed to two years. Similarly, the present 4-year combined program at the Alberta Hospital, Ponoka, should be shortened to three years.

60. Supplementary courses in nursing should be provided which would enable the registered psychiatric nurse to meet the requirements for the R.N. qualification.

61. The courses of training for ancillary nursing personnel should come under the jurisdiction of a director of nursing education appointed to designated hospitals and institutions.

62. The mental hospitals should organize continuing education programs for nursing and ancillary nursing staff.

63. The training program for "Mental Deficiency Graduate Nurses" at the Provincial School Hospital should come under the jurisdiction of a central educational body and eventually be transposed into a vocational program for wider recognition.

64. An Alberta Council of Nursing should be set up as a central planning body consisting of representatives of education, hospitals and other health services, and the public. The Council should be empowered under charter for the licencing of all categories of nursing personnel. It should be responsible for the coordination of all educational programs for nursing personnel.

65. Salary scales for nursing personnel should be reviewed. Recognition of the extra skills of the qualified psychiatric nurse should be respected in the salary scale.

66. A highly qualified psychiatric nursing consultant should be appointed to the Department of Health and advisors made available to the mental institutions with a view to ensuring that qualified nurses and ancillary nursing personnel under their supervision are deployed appropriately to their qualifications.

67. Public health nurses, given adequate training in mental health, and psychiatric nurses, given adequate training in community nursing, should be attached to Regional Public Health Units for home visitation and clinic service for mental health.

68. A research and planning council should be set up to develop multidisciplinary research in nursing practice for mental health.

69. All nursing education should come under the direction of the Department of Education.

70. Nursing education departments, separate from service, should be established at Ponoka and Oliver and should be headed by Directors of Nursing Education.

71. More adequate educational facilities (staff, library, classrooms, offices, change rooms, teaching aids) should be provided in the mental hospitals. Present inadequacies are of great concern to nursing staffs.

Other Therapists

72. The establishment for occupational therapists at each of the mental hospitals should be increased as rapidly as qualified occupational therapists become available.

73. The training program for occupational and recreational therapists at the University of Alberta School of Rehabilitation Medicine should be enriched by the inclusion of much more practical experience in dealing with mentally or emotionally disordered patients.

74. Those responsible for any new mental health program should also investigate and take action regarding the need for other therapists not mentioned above, e.g., speech therapists.

Other Mental Health Personnel

75. Because volunteers have made a valuable contribution to the care of the mentally ill through the mental hospitals, all possible encouragement should be given to the Canadian Mental Health Association Volunteer Program by the Government. Summer employment of members of the Alberta Service Corps should be continued and increased at mental hospitals.

Government Policy

76. To create a climate more conducive to professional personnel the Provincial mental hospitals and Guidance Clinics should be administered on the same basis and the same style as general hospitals and medical clinics and come under the provisions of the Hospital Insurance Act and prepaid medical insurance plans.

77. To encourage the participation of professional personnel in mental health, the services of psychologists, nurses and social workers should be covered under the Alberta Health Plan and the associated prepaid medical insurance plans.

78. An advisory committee on manpower for mental health comprised of representatives of the several mental health-related professional organizations should be appointed and used by the Minister of Health. (This proposed committee should be linked with the Health Services Advisory Council proposed in Chapter 5.)

PUPIL PERSONNEL SERVICES IN ALBERTA SCHOOLS

79. The principle of equality of opportunity in terms of education and mental health, should be extended to rural and smaller centres to the fullest possible extent. This implies an energetic attempt at local and Provincial levels to improve pupil personnel services outside the two large cities.

80. Training programs should be sponsored at the Universities in Alberta to meet the urgent need for professionally trained pupil personnel workers.

81. The Provincial Government should provide special grants to promote preventive services in pupil personnel departments of the various school systems.

82. The Provincial Government should sponsor or employ specialized pupil personnel staffs to work in rural areas, towns and small cities as "Regional Consultants". They might well be assigned to health regions and function in a coordinated manner with Guidance Clinics deployed in the same way.

83. Qualified guidance counsellors should be employed in full-time counselling positions in all regions.

84. A survey of the school population in Alberta should be conducted as a basis for planning services.

85. Provincial Guidance Clinics should diversify their services to meet needs of particular areas. Examples would include emphasis upon treatment rather than educational diagnoses in cities; closer liaison with schools in rural Alberta until pupil personnel workers become available.

86. Planners of programs, staff and facilities in mental health should recognize an increasing requirement for services in schools and elsewhere for seriously disturbed adolescents.

87. Administrators should allow public health nurses to join pupil personnel workers in providing services for children. In Alberta cities, public health nurses are sometimes bound by practices which prevent them from participating in team approaches to social problems. All resources should be available to all children.

88. Continued close cooperation between the schools and Provincial Guidance Clinics should be encouraged, with emphasis on teamwork rather than duplication of services.

89. Educational services in Government institutions should operate with a full complement of trained pupil personnel workers as well as professionally qualified teachers.

90. There should be a shift in emphasis from methods of cure to methods of early discovery, diagnosis and prevention.

FAMILY PHYSICIANS AND THE PSYCHIATRIST

91. The family physician should be regarded a key figure in the proposed delivery system. The system should be planned to provide him with necessary psychiatric instruction and consultation.

ACTIVE TREATMENT GENERAL HOSPITALS

92. The active treatment general hospital should be regarded as the primary hospital facility in the treatment of mental illness, when plans are implemented for the creation of a new delivery system.

93. Psychiatric units, which are integral parts of general hospitals, should be established at Lethbridge and Grande Prairie and existing units elsewhere should be strengthened as matters of high priority. The nature and location of the units should be determined by the local hospital Boards in consultation with the Provincial Government.

REGIONAL MENTAL HOSPITALS

94. The present mental hospitals should be retained and improved to serve in a regional and specialized capacity in the new delivery system.

95. Improvements at Oliver, Ponoka and Claresholm should take the form of developing special programs of active treatment for well defined groups, as discussed in this report. Minor physical modifications to facilitate segregation of certain groups will be required.

96. The observations made regarding Patient Care (in Chapter 3) should receive prompt attention.

97. If it is not clear from the presentation in Chapter 5, it is emphasized now that administrative authority should be delegated to local boards of these hospitals; that they should cease to come under a special section responsible for "mental" health; and that representatives of the hospitals should also be members of local and regional coordinating councils.

COMMUNITY FACILITIES

98. The Government should contract with the Canadian Mental Health Association to survey community facilities which are available for the rehabilitation of persons who have been mentally ill and recommend means by which they could function in a coordinated manner. Specific recommendations should also be submitted on additional facilities which may be required.

99. Through consultation between appropriate authorities, the integration of health units, guidance clinics, alcoholism clinics and welfare units should take place on a regional basis. Wherever possible, these facilities should be under one administrative head and in the same building.

EMOTIONALLY DISTURBED CHILDREN AND ADOLESCENTS

100. A province-wide demographic survey should be undertaken to determine the incidence, nature and degree of severity, in terms of required management and treatment, of emotional disturbances among children and adolescents.

101. A delivery of care system, as described in Chapter 12, should be worked out between local, regional and provincial authorities, making optimum use of available facilities and personnel and increasing them to meet needs as they are defined. Existing, urgent requirements for facilities south of Red Deer should receive high priority.

102. A consultant on child and adolescent care should be engaged to advise on #100 and #101, above. Consideration should be given to a permanent appointment within the Department of Health, or a Health Commission, if that recommendation of this report is adopted.

103. Coordination of all agencies and programs concerned with the delivery of care in this context should be assigned major importance in plans for improved mental health services.

INTELLECTUALLY AND NEUROLOGICALLY HANDICAPPED CHILDREN

104. It is recommended that services for intellectually and neurologically handicapped children be distributed, so far as practicable, to regions in the form of small training and treatment units, which would provide both day and residential facilities.

105. Operational authority over programs, staff, and facilities should be delegated to regional levels in the interest of making full use of local knowledge, support and concern. Central authorities should be responsible for operational guide lines, standards and financial support, only.

106. The growing multiplicity of government agencies, concerned with the health, education and welfare of children and their families, points to the need for at least coordination, if not integration.

107. It is strongly recommended that permanent local guidance clinics be established in all regions. In outlying districts, the Government should offer special monetary and other inducements to secure personnel. The formation of organized cadres probably would facilitate recruitment and maintenance of staff.

108. It is recommended that school boards in outlying districts be given special grants to enable them to hire teachers of special education, and other necessary pupil personnel workers, according to their needs, with added monetary inducement, if necessary.

109. Teachers' aides for special retarded classes or for other handicapped groups should be provided.

110. Communities should organize to provide volunteer services for day care programs, residential programs and home care services.

111. Through bursaries, other financial assistance, and other means, young people of promise should be encouraged through governmental action to undertake training for service with the handicapped.

112. Consideration should be given to the provision of residential and educational facilities for blind children in Alberta. At the present time there is no resource in the Province. It would seem that at least two centres, one in southern and one in northern Alberta are indicated.

113. Immunization procedures against Rubella (German measles), which can be responsible for deafness and other anomalies in children, should be investigated, and, if feasible, should be employed in this Province.

114. It is recommended that facilities other than the Glenrose School Hospital be provided for children with cerebral palsy.

115. Anti-convulsant medication should be provided for epileptic children without charge by the Government.

116. Immunization against viral meningitis, notably Ruboela (red measles) meningoencephalitis should be universally encouraged in the Province.

117. Continued action to stamp out tuberculosis in Alberta should be pursued.

118. While mass screening to discover anomalies of metabolic disorders is to be encouraged, the present state of knowledge in this regard does not seem to warrant mandatory screening of infants. It would probably be more effective to screen pregnant women. Research on the metabolic disorders of pregnant women is therefore to be encouraged.

119. Training programs for trainable mentally retarded individuals, now operated by the Alberta Association of Mentally Retarded, should be made the responsibility of the Department of Education and should be implemented by local school boards.

120. The Study Group recommends very strongly that (a) the facilities for mentally retarded at Red Deer should not be enlarged and (b) they should not be duplicated in other centres in the Province.

121. It is recommended that programs for educable mentally retarded children be geared open-endedly from the pre-school level to the secondary school level, with enough flexibility for transition to a variety of programs.

122. Pre-school age groupings are recommended to local and central authorities, both for diagnosis and for early socialization of the retarded child. Continuous porgrams are essential for the optimal development of these children.

123. At the local level, counselling services should be available to parents and to families of retarded children on a continuous basis as soon as a diagnosis of mental retardation has been affirmed.

124. At the secondary school level, particular emphasis must be placed on providing work experience. In the transition from school to full-time employment, a community agency should be available to assist in the guidance and placement of these young people.

125. It is strongly recommended that legislation be implemented to permit mentally retarded students to remain in school, under the responsibility of the Government, until age 21. To cut off the responsibility of the Department of Education to these children at age 16 is most unrealistic in view of their slow learning rate and their restricted range of employability.

126. It is recommended that the Provincial Government take the lead in providing employment for mentally retarded persons in Government installations throughout the Province to the limit of feasibility. The problem of employability of adults was not directly of concern. However, the committee felt that the employability of the mentally retarded is of importance in designing his training program, in assisting him to self development and esteem and to community acceptance.

127. In view of the large number of students of borderline intelligence and the potential loss of human talent, as they experience failure and frustration and develop aberrant behavior, it is strongly recommended that:

a. Greater diversity of programs and flexibility of standards be characteristic of the Alberta public school curriculum at all levels.

b. Individualized instruction and individualized promotion become more pronounced.

c. Teaching techniques known to facilitate learning among slow students be given greater emphasis.

d. School systems, wherever possible, be assisted to employ auxiliary personnel (psychologists, reading specialists) to assist with special programs.

e. The Department of Education provide these specialists on a consultant basis, to school systems unable to provide their own.

f. Special preschool and language-development programs be established in areas where a high proportion of the population is bilingual or New Canadian, with financial and other assistance from the Provincial Government.

g. Special junior and senior high school pre-employment and work experience programs be developed, to assist less able youngsters to become gainfully employed, self-respecting citizens. Liaison between educators and outside-school agencies is essential.

h. Access to a high school diploma, via satisfactory achievement in "modified" vocational courses, be made possible for those students who wish to work toward that goal.

i. As a final recommendation, the Study Group strongly recommends that some independent body be appointed periodically to evaluate and report upon the implementation of these recommendations.

MENTAL HEALTH SERVICES AT UNIVERSITIES

128. Universities should maintain adequate, interrelated health and counselling services, including ready access to psychiatric consultation in either case. Adequacy in the case of counselling services, the subject of Chapter 14 , should be determined in relation to:

   a. Reasonable demands for highly specialized services, not simply information and advice, which academic departments and advisors, and other non-academic officers and departments, should be expected to provide.

   b. The necessity to maintain working conditions, which will attract the highly qualified staff, who are able to provide the specialized services. Reference is made here to an academic role through joint appointments and an opportunity for research or professional development.

   c. The need for on-going operational research within the counselling service, aimed at evaluating its effectiveness and giving direction to its development.

   d. The need for continuous, time-consuming liaison between the service and other staff concerned with student welfare and development.

129. Further to 128 (b), above, if universities establish departments or institutes of applied behavioral science, consideration should be given to the incorporation of counselling services.

130. Universities should encourage and support the type of research named in 128 (c), above. It will be clear from this presentation that more information is required about the incidence and nature of emotional disturbances and maladaptive behavior among university students and about the stresses of the university environment, to permit systematic planning of remedial and preventive measures within a university's responsibility, including the provision of adequate staff.

131. More emphasis and resources should be assigned to prevention, early detection and treatment of maladaptive behavior and emotional disturbance by responsible agencies outside the universities.

THE ELDERLY

132. Adequate statistics should be obtained and retained for planning purposes in connection with the care of the elderly.

133. Better transportation facilities to accommodate visitors to mental hospitals should be provided.

134. Privacy in lavatories, improved bathing arrangements, hand-rails, opportunity for exercise, replacement of narrow beds, improved occupational therapy and an examination of security arrangements at Claresholm and Rosehaven are indicated.

135. Criteria for assigning patients to Claresholm and Rosehaven should be critically examined.

136. Greater consideration should be shown for the elderly in nursing homes and auxiliary hospitals with respect to the timing of the evening meal and the "open door" policy for lavatories.

137. There should be some specialization by nursing homes for different ailments and the ideal bed capacity of nursing homes should be determined.

138. Psychiatric consultation should be available to nursing homes and auxiliary hospitals.

139. There should be a substantial increase in the number of auxiliary hospitals and nursing homes in accordance with the plan for a new delivery system.

140. Financial support for the Victorian Order of Nurses should be improved to support their valuable work in the home care field.

141. There should be an increase in the number of lodges and units of senior citizens' homes, more single rooms in future lodges; and transport facilities for the elderly residents should be improved.

142. Better records should be kept at institutions; there should be a more liberal provision of staff in all institutions; and staff training courses are required for those who work with the aged.

143. Special emoluments should be provided for staff in isolated and outlying districts; non-professionals should be used to a greater extent, under proper supervision and following appropriate training; psychiatric consultation should be subsidized.

144. Service clubs and young people, like the Alberta Service Corps, should consider what action they might take to brighten the lives of elderly patients.

145. The sum of $90,000 should be allocated out of public health funds to the Victorian Order of Nurses for the initiation of a pilot program of organized home care.

146. Local communities and organizations should utilize the financial provisions of the preventive social services legislation to initiate or extend home maker/home help services for the elderly.

147. The Government of Alberta should institute a plan for subsidized rents for senior citizens, as well as expand the existing program for single unit accommodation and homes. The amount of the proposed subsidy should be based on the difference between the cost of renting a medium priced one-bedroom apartment and 25 percent of pension.

148. The Department of Welfare should encourage local agencies to establish information and counselling centres for the elderly under existing financial provisions of preventive social services legislation. Such centres should include staff with experience in legal and financial matters.

149. Organizations responsible for adult education should provide daytime classes catering especially to the interests of older citizens with appropriate teaching methods at minimal costs to participants, and arrangements should be made to provide for transporting students where necessary.

150. The Department of Labour, after consultation with industry and interested trade unions, should suggest to the Federal Government that special sections of Canada Manpower Centres be established for registering those retired people who wish to continue in full or part-time employment. The Canada Manpower Centres should embark on a program of advertising, so that potential employers are made aware of this source of professional and skilled workers.

151. All voluntary societies in the Province should make a special and continuous effort to utilize and to welcome the services of older people.

152. The Department of Welfare using the provisions of existing preventive social service legislation, should underwrite 80 percent of the cost of a pilot project day-care centre in one of the middle-sized cities of Alberta (e.g. Red Deer or Medicine Hat), such a centre to provide many of the facilities suggested in other recommendations, in addition to a sheltered workshop.

153. Employers, trade unions, and educational institutions should sponsor retirement preparation courses. Such courses should include wives of employees and utilize the services of presently retired people.

154. School, university, and adult education courses in medicine, physical education, recreation, dentistry, biology, sociology and psychology should place far greater emphasis than heretofore on material concerned with the later years of life.

NORTHERN MENTAL HEALTH PROBLEMS

155. A psychiatric unit should be located in Grande Prairie as an integral part of the existing general health facilities, not something separate organizationally or professionally. The unit should come under local administrative control, as a part of the Municipal Hospital. Its construction is a matter of high priority.

156. The psychiatric unit should have no more than 60 beds as a start, having regard for Yorkton's experience where approximately .7 beds per 1000 of population have proven sufficient to attend to all mentally ill persons in the region who are not chronic cases. A larger ratio may be required in the north if clinical judgment regarding incidence is supported by factual evidence.

157. Forensic problems and patients, who require long term or highly specialized care, should be referred to the Alberta Hospital, Edmonton.

158. A consulting psychiatrist should be made available. He should have a full-time geographical appointment with an adequate basic salary. In addition, he should have a consultative practice and, desirably, a sessional appointment with the Department of Psychiatry at the University of Alberta in the field of Community Psychiatry.

159. Higher salaries than those prevailing in urban areas should be paid to attract psychologists and social workers and they should have relatively more opportunities to attend seminars and conferences. They should also be encouraged to accept joint appointments with the existing Junior College.

160. The possibility of developing, with British Columbia, a joint, comprehensive mental health program for the Peace River country should receive further study.

161. A close watching brief be maintained by local, regional and governmental authorities to ensure that the needs of the region are being met, having regard for possible variations in incidence and the relative isolation of communities such as Peace River.

THE EUGENICS BOARD

162. It is recommended that the composition of the Eugenics Board be revised in accordance with Chapter 17 and that the number of Board members be increased to five. Procedures should also be modified, as recommended.

ADDICTION

163. The early detection and treatment resources of the school systems and guidance clinics should be strengthened and extended as one means of preventing and reducing addiction. All school divisions require pupil personnel services. Each of the proposed health regions requires a clinic.

164. The abuse of alcohol and the abuse of drugs should be treated as one problem and an aspect of mental health, in the development of services for detection, diagnosis, treatment, rehabilitation, prevention and research.

165. The delivery system, in the case of drug and alcohol abuse, should be the same as in other forms of mental illness and maladaptive behavior; that is, first, non-hospital facilities; then active treatment general hospitals; followed by longer term facilities or chronic facilities, if necessary (regional mental hospital); and rehabilitation services at each point in the system.

166. Detoxification of acute alcoholics should take place at general hospitals, not mental hospitals, with rare exceptions.

167. Special longer term facilities (half-way houses, boarding homes and rehabilitation camps) should be created with Government support and community participation.

168. Legislation should be enacted to provide for absolute and conditional discharge in relation to drunkenness, and possibly for drug abuse, too.

169. Marijuana should not be classed as a narcotic. It would be properly listed under the Food and Drugs Act. Much more information is needed about possible dependence on it and its part, if any, in the use of addictive drugs.

170. The replacements for the Division of Alcoholism should be responsible for plans, education and consultation regarding addiction generally as staff members of the proposed Health Services Commission.

171. Continuing discussion and cooperation with the provinces and the Federal Government should take place to develop consistent policies and shared research programs related to drug and alcohol abuse.

172. Alcoholism clinics should be combined with guidance centres, health units and welfare facilities, on a regional basis, as health and welfare units.

173. Physicians and pharmacists should join forces, as proposed earlier in this Chapter, to improve control over drugs, which are of concern in the context of addiction.

174. A behavioral research institute should be established at one or more Alberta universities to conduct basic and applied research on drug and alcohol abuse and other aspects of mental health.

FORENSIC SERVICES

175. Forensic services should be provided on a modest scale, but on a province-wide basis, at strategic locations, to comprise initially: Alberta Hospitals, Edmonton and Ponoka; and detention centres at Edmonton, Calgary, Lethbridge, Medicine Hat, and Grande Prairie.

176. Professional staff services should be provided from mental health facilities including mental hospitals (on a regional basis), general hospital psychiatric units and guidance clinics.

177. Training of a few professional staff in the forensic specialty should be started soon.

178. Interprovincial collaboration in the development of a western facility for the criminally insane should be explored actively.

RESEARCH

179. Research on aging should be the responsibility of an Alberta Institute on Aging, which should be established with support from the Human Resources Research Council at the University of Calgary. The initial financial support should be not less than $75,000 annually for a five-year period. (This project is already in a planning stage and has been documented.)

180. Subject to satisfactory documentation, it is recommended that a project on social and preventative psychiatry be supported by the Council at the University of Alberta with a grant-in-aid to be negotiated.

181. Research on incidence, treatment evaluation, etiology and therapeutic methods should be sponsored by the Council through similar grants-in-aid to scholars at Alberta universities and provincial institutions and as institutional grants to Alberta universities. A sum of approximately $150,000 should be made available in the first year for that purpose, to be divided according to advice from the Universities.

182. Evaluation of training programs would be studied appropriately through in-house research of the Council if care is taken to ensure objectivity and independence.

183. It is also recommended that a residency in research for two psychiatric residents at $12,000 per year be established; that five research fellowships for Master's and Ph.D. students in psychology at $5,000 a year be created to support graduate students who wish to do research in the field of mental health; and that two research fellowships at $5,000 per year for Master's and Ph.D. students in sociology and anthropology or social welfare, be established to support graduate students who wish to do work in the same field.

184. The allocation of money for mental health research should be determined through the assistance of an Advisory Board on Mental Health Research.

This Advisory Board would consist of personnel having demonstrated research capabilities and experience in the mental health field. The Advisory Board, operating under the present terms of reference of the Human Resources Research Council, would as part of its duties ensure that all mental health research proposals were evaluated competently and fairly.

In addition, it would be responsible for ensuring that research programs under its aegis were relevant to the needs of the Province of Alberta and would, if necessary, initiate research programs or contract research that it deemed necessary.

185. The Chairman of the Advisory Board should be appointed as a member of the Human Resources Research Council in order to ensure that the mental health needs of the Province of Alberta have a voice in the policy decisions and budget allocations of the Council.

LEGISLATION

186. Legislation concerning mental health should be examined in relation to the new concepts and the new delivery system, which are proposed in this report, if they are approved. The object of the examination would be to determine whether any modifications are necessary. An outside consultant should be engaged for that purpose.

IMPLEMENTATION

187. Because the recommendations relate to the responsibilities of several departments of government concerned with human resources, coordination of the implementation of the report should be assigned to the Human Resources Development Authority.

188. It is recommended that implementation of the above recommendations be undertaken in systematically planned phases to avoid disruption in the present system. A professional advisor or advisory group should be appointed to assist the Human Resources Development Authority in this regard.

REVIEW

189. There should be a full scale review of action taken on this report, of results of that action and of need for further change or development in Alberta's mental health services in three years' time (1972). In the interim, annual evaluations of the new programs should be presented to the Legislative Assembly.

CHAPTER 24

PRIORITIES

The following proposals should be assigned the highest priority. Action should be taken on them at once if they are approved by the Government.

1. Adoption of the new delivery system as described in Chapter 4.
2. The provision of psychiatric units at the Lethbridge and Grande Prairie Municipal Hospitals and the establishment or strengthening of units elsewhere (Chapters 9 & 16).
3. The development of a new organizational and administrative structure for health services in the Province (Chapter 5).
4. Admission practices relating to mental hospitals to be changed as soon as possible (Chapter 3).
5. The provision of more auxiliary and nursing home facilities, to relieve the pressure on active treatment general hospitals. Special nursing homes should be provided, as required (Chapter 15).
6. The introduction of an active program of recruitment and training of mental health professionals at higher pay scales (Chapter 6).
7. The improvement of pupil personnel services outside the two large cities (Chapter 7).
8. The coordination of community facilities related to mental health (Chapter 11).
9. The integration of health units and clinics and, possibly, welfare units, on a regional basis (Chapter 11).
10. The improvement of standards, facilities and services in connection with treatment and care of emotionally disturbed, intellectually and neurologically handicapped people (Chapters 12 & 13).
11. The reduction of patients in mental hospitals as community facilities are developed (Chapters 3 & 11).
12. The reallocation of departmental responsibilities from the Department of Health to other departments in the cases of nursing education, the education of all trainable persons and recreational activities within mental hospitals (Chapters 3, 6 & 13).
13. The introduction of a substantial research program in support of mental health (Chapter 21).

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